Government Performance and Results Act Plan and Report

Part I

From the Administrator

In accordance with the Government Performance Results Act of 1993, I am pleased to present the HHS submission of the SAMHSA 2005 Performance Plan and FY 2003 Performance Report. In keeping with HHS and OMB guidance, the GPRA plan and report are now consolidated with the budget document and will also be consolidated for submission to OMB and the Congress.

SAMHSA's vision as an agency of the Federal Government is "A Life in the Community for Everyone." SAMHSA's mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. SAMHSA was established in 1992 and reauthorized in 2000. SAMHSA administers a combination of categorical, formula, and block grant programs and data collection activities. Programs are carried out through the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Office of Applied Studies (OAS). Authorization for SAMHSA and its programs will expire at the close of FY 2003. A package of legislative proposals will be submitted under separate cover.

SAMHSA provides services indirectly through grants and contracts to others. SAMHSA's resources enable service capacity expansion and the implementation of evidence-based practices. The agency seeks to engage all communities in the provision of effective services by making sure that they have access to the latest information on evidence-based practices and accountability standards.

Programs in the Centers for Substance Abuse Treatment and Prevention and Mental Health continue to support and implement Agency goals of Accountability, Capacity, and Effectiveness**.** Data from the Office of Applied Studies is relied on by ONDCP and other partners. Our programs are increasing access to and effectiveness of treatment and prevention services in support of the President's priorities. The GPRA data included here demonstrates that that the return on investments in treatment and prevention services for substance abuse and mental health are significant. For example, the 2004 OMB PART review of GPRA and other data found that the three programs examined were effective.

For the 2005 budget submission, a number of significant improvements have been made in our ability to report accountability data. In response to OMB and HHS guidance, SAMHSA has identified efficiency measures for all of its programs reporting data in 2005. In addition, SAMHSA has set long-term measures consistent with the Performance Partnership Grant goals that have been developed with our State partners.

I am proud to report to you and the Nation on SAMHSA's results for fiscal year 2003 GPRA goals and, to further accountability, to set Performance Plans for fiscal years 2004 and 2005.

Charles G. Curie, M.A., A.C.S.W.
Administrator, Substance Abuse and Mental Health Services Administration

Part II

Executive Summary

This document includes the Substance Abuse and Mental Health Service Administration (SAMHSA) HHS FY 2005 Performance Plan and 2004 Performance Plan, and the FY 2003 Performance Report including the most recent performance data on FY 2003 and earlier performance goals. Resources for achieving performance goals are shown for each program. In order to keep the GPRA plan at a manageable length, SAMHSA generally does not include new programs in the GPRA plan until grants have been awarded and data collection is underway. An exception has been made for two major new substance abuse treatment programs. A table summarizing the areas in which new programs are proposed in the FY 2004 and FY 2003 Congressional Justifications may be found in section one of this document A-8.

A. Agency Vision and Mission

SAMHSA's vision as an agency of the Federal Government is "A Life in the Community for Everyone." SAMHSA's mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. SAMHSA was established in 1992 and reauthorized in 2000. SAMHSA administers a combination of categorical, formula, and block grant programs and data collection activities. Programs are carried out through the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Office of Applied Studies (OAS). Authorization for SAMHSA and its programs will expire at the close of FY 2003. A package of legislative proposals will be submitted under separate cover.

SAMHSA provides services indirectly through grants and contracts to others. SAMHSA's resources enable service capacity expansion and the implementation of evidence-based practices. The agency seeks to engage all communities in the provision of effective services by making sure that they have access to the latest information on evidence-based practices and accountability standards.

SAMHSA has developed a draft strategic plan. Agency goals are Accountability, Capacity, and Effectiveness. A chart showing the vision, mission, goals and objectives may be found in the overview of the budget section. Pending broad constituent and public input and HHS approval, SAMHSA intends to issue the new strategic plan in 2003. The FY 2004 and FY 2005 budget submissions align the budget request with the three goals. In FY 2005, SAMHSA has categorized programs according to the Capacity and Effectiveness goals rather than by Targeted Capacity Expansion and Best Practices.

SAMHSA's matrix of program priorities and cross-cutting principles has guided the agency's daily operations and overall program and management decisions for the past two years. The program categories used in the FY 2004 and FY 2005 budget requests align the budget request

with the matrix. The updated matrix is included at the end of this section. Action plans are under development for each program priority area.

SAMHSA's planning and budget decisions emphasize alignment among HHS Goals, SAMHSA's Draft Strategic Plan, and the Administrator's Performance Contract. SAMHSA's draft strategic plan directly supports HHS program objectives 1 and 4, and all management objectives. SAMHSA's FY 2005 budget proposals are entirely consistent with stated outcomes of SAMHSA's draft strategic plan. Examples of strategic plan outcomes include:

- Complete implementation of Block Grant performance measures (Accountability)
- Double the number of service improvements implemented (Effectiveness)
- Expand the National Registry of Effective Programs to substance abuse treatment and to mental health (Effectiveness)
- Achieve timely implementation of PART program review findings (Accountability)
- Achieve and maintain a "green light" on all HHS/OMB management reviews (Accountability)

The FY 2005 budget submission and GPRA plan have been developed within the context of the new strategic framework. SAMHSA's strategic plan explicitly supports HHS Strategic Plan Goals 1.4, 1.5 and 3.5, though agency activities support many additional HHS objectives. The draft vision, mission, goals and objectives for the agency and the matrix of priority areas may be found in the overview of the budget document.

SAMHSA works in partnership with States, communities, private organizations, and other Federal agencies. SAMHSA administers categorical, formula, and block grants and contract activities in varied program and data collection areas. Programs are carried out through the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Office of Applied Studies (OAS).

SAMHSA's proposed FY 2005 budget emphasizes two Presidential priorities: the third year of the President's Drug Treatment Initiative, and ensuring a strong programmatic base to support the President's emphasis on improving mental health services. The budget summary table may be found at the beginning of this document. The FY 2005 budget priorities are amply reflected in the FY 2005 GPRA plan and performance measures and their set targets for future years guide appropriations requests.

B. Overview of the Plan and Performance Report

Summary of Measures

SAMHSA has 74 total measures for 39 reported programs in 2005, which is a 14% reduction from the number reported in 2004. Data has been collected for only one 2003 measure to date, which was met. Data will be reported against 2003 targets in subsequent budget submissions as it is collected. SAMHSA has 41 efficiency measures for 2005. Long-term efficiency measures

are being developed through the OMB PART process. The OMB PART review focused on the block grant programs for FY 2003, and was a significant factor in adding long-term measures for these programs.

SAMHSA is continuing its efforts to improve its block grant measures and their data collection which remains a significant challenge. SAMHSA has been working with the States and on December 24, 2002 published a Federal Register Notice (FRN) on the Block Grant measures as part of the Performance Partnership Grant process. The Agency is using the comments from the public to improve measures that will contain specific measures that will be collected and reported by the States. A report to Congress is being developed that contains the measures and strategies for assisting the States improve their data infrastructure for reporting performance.

Program Performance Report Summary Table

	Measures in Plan	Results Met	Results Not Met	Unreported to Date
1999	39	35		1
2000	137	75		32
2001	134	76		37
2002	90	38	13	39
2003	83	1	0	82
2004	86	NA	NA	NA
2005	74	NA	NA	NA

Narrative Description of Report

The GPRA plan and report are now contained as an appendix to the budget document in order to further implement performance based budgeting consistent with HHS and OMB guidance contained in the cover letter. A table of contents specific to the GPRA section is provided according to HHS guidance and to guide the reader through the presentation of the performance plan and results for each of SAMHSA's program Centers and Offices. Because SAMHSA's budget line item structure mostly follows from SAMHSA's three primary programmatic areas (mental health services, substance abuse prevention, and substance abuse treatment), the budget narrative and GPRA plan also are organized by those programmatic areas. Performance measures specific to the President's Management Agenda and priorities are contained in tables before the appendix.

SAMHSA programs continue to demonstrate effective program performance. Performance highlights are located throughout the preceding budget section of this report. In general, programs are producing annual performance data and annual performance targets have been met. Certain programs present performance challenges either in collecting performance data or in reaching performance targets. Where targets have not been consistently reached, corrective action plans have been included. Obtaining Block Grant program performance data from State partners has continued to be a challenge. For the Block Grant programs the Performance Partnership Grant (PPG) approach is developing a report to Congress that contains specified measures and strategies for collecting accountability data from the States. More information on the PPGs can be found in the discussion of the Block Grant programs.

Part III

GPRA TABLE OF CONTENTS

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PART IV

PERFORMANCE PLAN AND REPORT

Introduction

Mission and Vision

SAMHSA's vision as an agency of the Federal Government is "A Life in the Community for Everyone." SAMHSA's mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. SAMHSA was established in 1992 and reauthorized in 2000. SAMHSA administers a combination of categorical, formula, and block grant programs and data collection activities. Programs are carried out through the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Office of Applied Studies (OAS). Authorization for SAMHSA and its programs will expire at the close of FY 2003. A package of legislative proposals will be submitted under separate cover.

SAMHSA provides services indirectly through grants and contracts to others. SAMHSA's resources enable service capacity expansion and the implementation of evidence-based practices. The agency seeks to engage all communities in the provision of effective services by making sure that they have access to the latest information on evidence-based practices and accountability standards.

Description of Agency

SAMHSA is a small agency of approximately 525 employees located in Rockville, Maryland. SAMHSA's has three primary programmatic areas of mental health services, substance abuse prevention, and substance abuse treatment each of which is organized by Center.

Program types (e.g., block grant; targeted capacity expansion; best practices) are clearly designated in each narrative within the budget narrative and the GPRA plan. There is clear reference in each program narrative to the SAMHSA strategic goal i.e., Accountability, Capacity, Effectiveness, that each program supports.

SAMHSA does not include new programs in its GPRA plan until grants have been awarded and collection is underway. In looking toward programs that may be included in the GPRA plan in the future, appendix A-8 of the budget presents information on planned discretionary programs for FY 2004 and 2005.

Summary of Measures

SAMHSA has 74 total measures for 39 reported programs in 2005, which is a 14% reduction from the number reported in 2004. Data has been collected for only one 2003 measure to date, which was met. Data will be reported against 2003 targets in subsequent budget submissions as it is collected. SAMHSA has 41 efficiency measures for 2005. Long-term efficiency measures are being developed through the OMB PART process. The OMB PART review focused on the block grant programs for FY 2003, and was a significant factor in adding long-term measures for these programs.

SAMHSA is continuing its efforts to improve its block grant measures and their data collection which remains a significant challenge. SAMHSA has been working with the States and on December 24, 2002 published a Federal Register Notice (FRN) on the Block Grant measures as part of the Performance Partnership Grant process. The Agency is using the comments from the public to improve measures that will contain specific measures that will be collected and reported by the States. A report to Congress is being developed that contains the measures and strategies for assisting the States improve their data infrastructure for reporting performance.

Narrative Description of Report

The GPRA plan and report are now contained as an appendix to the budget document in order to respond to HHS and OMB guidance . A separate table of contents is furnished to guide the reader through the introduction and the presentation of the performance plan and results for each of SAMHSA's program Centers and Offices. Each of the performance tables in the GPRA plan and report contain our results and plan for program performance. Each outcome and efficiency measure is identified. In the reference column of the performance table icons identify those measures that measure the HHS Strategic Plan objective, Health People 2010 goals, and an icon for those measures directly related to the President's Management Agenda, see symbols key below:

Key for Performance Table Symbols

HP	Healthy People Goals and Objectives
HHS SP	HHS Strategic Plan Goals
	President's Management Agenda

In FY 2002, SAMHSA's PART reviewed programs scored relatively high to other programs reviewed. In the second year of the OMB Program Effectiveness Review, programs being reviewed are the CSAT-CSAP and CMHS Block Grant programs. SAMHSA is in the process of finalizing these goals with the Department and OMB and is aligning the PART measures and current GPRA measures for those programs. SAMHSA implemented a similar process for other SAMHSA programs last year. This budget document contains a summary of the 2002 PART findings on page 139.

Through the PART process SAMHSA has set both efficiency and long-term measures. HHS has defined efficiency measures to include measures that track which resources are turned into goods or services. Efficiency measures are also identified throughout the report in the performance report with an "E" symbol in the reference column.

SAMHSA's draft vision, mission, goals, and objectives, as well as the matrix of program priority areas, are discussed in detail in the preceding budget narrative. Budget and GPRA documents are organized according to SAMHSA's matrix program priority categories. These program priority areas constitute the strategies SAMHSA will employ in carrying out its strategic plan, and action plans will be developed for each area. Identified performance needs within each program priority area and drove FY 2005 budget recommendations.

Contributions to Priority Initiatives

1. President's Management Agenda

SAMHSA has made numerous achievements in implementing the President's Management Agenda that are discussed in detail in the budget overview. This GPRA report identifies measures tracking SAMHSA's results with one of the five priority areas identified in the President's Management using a White House symbol. This submission of GPRA to HHS marks significant progress toward the integration of budget and performance. Accomplishments to this priority initiative include:

- Alignment of the GPRA and budget documents by Center and the Program Priority Matrix areas;
- Combining both documents into one volume for easier reference and use of performance information to support appropriation requests as directed in the HHS guidance, and
- Reduction in the number of performance measures to a more manageable and useful number focusing on outcomes and efficiency.

2. HHS Strategic Plan

SAMHSA has developed a draft strategic plan. Agency goals are Accountability, Capacity, and Effectiveness. A chart showing the vision, mission, goals and objectives may be found at the end of this section. Pending broad constituent and public input and HHS approval, SAMHSA

intends to issue the new strategic plan in 2003. The FY 2004 and FY 2005 budget submissions align the budget request with the three goals. In FY 2005, SAMHSA has categorized programs according to the Capacity and Effectiveness goals rather than by Targeted Capacity Expansion and Best Practices. SAMHSA's strategic plan goals are aligned with HHS' strategic plan goals.

SAMHSA's matrix of program priorities and cross-cutting principles has guided the agency's daily operations and overall program and management decisions for the past two years. The program categories used in the FY 2004 and FY 2005 budget requests align the budget request with the matrix. The updated matrix is included at the end of this section. Action plans are under development for each program priority area.

3. Healthy People 2010

The Substance Abuse and Mental Health Services Administration (SAMHSA) shares lead responsibility with the National Institutes of Mental Health (NIMH) for Healthy People Focus Area 18 on Mental Health and Mental Illness, and with the National Institute on Drug Abuse (NIDA) the lead responsibility for Focus Area 26 on Substance Abuse. Within each of these focus areas lie several objectives which center on interventions designed to reduce or eliminate illness, disability, and premature death among individuals and communities. Each objective has a target for specific improvements to be achieved by the year 2010. In addition, SAMHSA is responsible for the Leading Health Indicators (a measurement tool developed to determine the health of the nation over the next 10 years.) on substance abuse and mental health, currently there are three (3) LHIs addressing substance abuse and one (1) that addresses mental health. Health People objectives tend to focus on national health objectives, whereas SAMHSA's GPRA plan focuses on program results.

SAMHSA's Administrator and key senior staff are responsible for briefing the Surgeon General on the latest data for the objectives for which they are responsible. This includes providing the most recent data for the objectives and progress toward reaching the targets. SAMHSA's progress reviews for mental health and substance abuse are scheduled for December 2003 and August 2004, respectively.

SAMHSA is currently convening a workgroup and developing a work plan to prepare for these progress reviews. Members of the work group include Healthy People staff leads from each of SAMHSA's Centers, OAS staff, staff from the Office of Disease Prevention/Health Promotion and the National Center for Health Statistics.

B. Discussion and Performance Analysis

Mental Health Services

The Center for Mental Health Services (CMHS), established by the 1992 ADAMHA Reorganization Act, leads Federal efforts in caring for the Nation's mental health by promoting effective mental health services.

CMHS provides Federal fiscal and policy support for the application of evidence-based, community-focused mental health services by States, local governments, and service providers at the community level. These services represent the culmination of decades of work to create an effective community-based mental health service infrastructure throughout our Nation. CMHS disseminates new knowledge about the effectiveness of treatment, and supports States and local communities in adopting evidence-based interventions.

Approximately 54 million Americans have a mental illness. The people affected by the work of CMHS include adults with serious mental illnesses, children with serious emotional disturbances, those at risk for developing these illnesses, and the families, employers, and communities of affected individuals.

The President's New Freedom Commission on Mental Health is developing recommendations on improving the Nation's mental health services delivery system. SAMHSA's FY 2004 budget proposal supports the President's emphasis on improving mental health services by proposing increases in the PATH homeless services formula grant program and the Children's Mental Health Services program, as well as supporting several new efforts. For more detail, please refer to SAMHSA's FY 2005 budget narrative.

Programs included in this report are:

2.1 Child Traumatic Stress Initiative
2.2 Statewide Family Network Program and Statewide Consumer Network Grants
2.3 Planning, Designing, and Assessing Service System Models for American Indian and Alaska Native Children and Their Families (Circles of Care)
2.4 National Mental Health Information Center (formerly Knowledge Exchange Network)
2.5 Community Action Grants for Service Systems Change
2.6 HIV/AIDS Minority Mental Health Services
2.7 Comprehensive Community Mental Health Services for Children and Their Families
2.8 Protection and Advocacy for Individuals with Mental Illness
2.9 Projects for Assistance in Transition from Homelessness (PATH)
2.10 Community Mental Health Services Block Grant

Programs of Regional and National Significance (PRNS)
Children's Priority Area

2.1 Child Traumatic Stress Initiative

Performance Goals *Strategic Goal: Effectiveness*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of children and adolescents reached by improved services. (O,E)	FY 05: 25,200 FY 04: 24,000 FY 03: Establish baseline FY 02: Preliminary data*	FY 05: TBR 12/05 FY 04: TBR 12/04 FY 03: TBR 12/03 FY 02: 5933*	**HHS SP 2, 3.5**
Total Funding:	**2005: $20,000** **2004: $ 20,000** **2003: $ 29,805** **2002: $ 30,000** **2001: $ 10,000**		

***Preliminary data that represents only one-quarter of program direct services for FY 2002; this was start-up year for the program.**

Intervention in the aftermath of trauma is perhaps the most significant clinical issue in child and adolescent mental health. Promising interventions for child trauma have been identified, but much needs to be done to provide these services to children and their families. The purpose of the National Child Traumatic Stress Initiative (NCTSI) is to improve treatment and services for all children and adolescents in the United States who have experienced traumatic events. The NCTSI seeks to 1) improve the quality, effectiveness, and availability of therapeutic services delivered to traumatized children and adolescents, 2) further the understanding of the individual, familial, and community impact of child and adolescent traumatic stress and the methods used to prevent its consequences, and 3) reduce the frequency and consequences of traumatic events on children and adolescents through greater public recognition of the issue, deeper understanding of their sequelae, and improved prevention and treatment services.

As part of NCTSI, the National Center for Child Traumatic Stress (NCCTS) was established to coordinate a national effort to increase services and raise the standard of care for traumatized children. The program established 30 treatment development and community service centers to treat children who have experienced trauma. Initial quarterly reporting shows an average of over 5000 traumatized children and their families in 18 states directly benefiting from services delivered as a result of the NCTSI. Many thousands more will benefit from the improvement in treatments, the proliferation of training opportunities, and the many technical, educational and practical information resources that will be made available through the NCTSI Resource Center.

Measure 1. Increase the number of children and adolescents reached by improved services

The number of clients who directly and indirectly receive improved services is an important measure of the success of a program aimed at children and adolescents who have experienced trauma. A formula will be developed in order to accurately report this measure.

2.2 Program Title: Best Practices: Statewide Family Network and Statewide Consumer Network Grants

Performance Goals *Strategic Goal: Effectiveness*	*Targets*	*Actual Performance*	*Refer-ence*
1. Number of members involved in Statewide consumer organizations and Statewide Family Network activities (E, O)	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: Establish baseline	FY 05: TBR 10/05 FY 04: TBR 10/05 FY 03: TBR 10/03 FY 02: 3,292	**HHS SP 3.5**
Total Funding:	**2005: $3,400** **2004: $ 3,400** **2003: $ 3,000** **2002: $ 4,722** **2001: $ 4,174**		

Program Description and Context

The Statewide Consumer Network program promotes improved mental health services through increased consumer involvement. Grants funded through the Consumer Networks program assist consumers with serious mental illnesses to participate in the development of policies, programs, and quality assurance activities related to mental health through State-level consumer networks. Grants were awarded in FY2001 to 24 recipients in 23 States.

The Statewide Family Network program supports State-level family network organizations to manage a set of activities that will assist family members to participate in the development of policies, programs, and quality assurance activities related to children's mental health. Grants were awarded in FY02 to 42 recipients in 40 States (including the District of Columbia and the Territory of Guam).

Performance Analysis

Measure 1: Number of members involved in Statewide consumer organizations and Statewide Family Network activities

This measure reflects an important program outcome in promoting mental health services through increased consumer participation and involvement. The program seeks to increase performance on this measure through the use of grants to support increased State consumer and family networks. Future budget requests for this program will reflect the need to meet set targets.

Reporting for the measure has been changed to include a count of the number of participants in program activities. Baseline data and targets have been reported above.

2.3 Models for American Indian and Alaska Native Children and Their Families (Circles of Care)

Performance Goals *Strategic Goal: Effectiveness*	*Targets*	*Actual Performance*	*Refer-ence*
1. Readiness to adopt a system of care Measure to be modified for FY 03: Adoption of system of care	FY 05: TBR 11/03 FY 04: TBR 11/03 FY 03: 100% FY 02: Establish baseline	FY 05: TBR 11/05 FY 04: TBR 11/04 FY 03: TBR 11/03 FY 02: 100%	**HHS SP 3.5**
Total Funding:	**2005: $3,000** **2004: $3,000** **2004: $ 3,000** **2003: $ 3,000** **2002: $ 2,720** **2001: $ 2,428**		

Program Description and Context

The Circles of Care Grants, awarded in FY 2001 to seven recipients in seven States, provides funds for tribal and urban Indian communities to plan, design, and assess the feasibility of implementing a culturally appropriate system of care for American Indian/Alaska Native children and their families who are experiencing or are at risk for serious emotional/behavioral disturbance. The grant does not fund direct services. Circles of Care grantees develop systems of care models designed by American Indian/Alaska Native community members to achieve their selected emotional, behavioral, educational, and vocational outcomes for their children.

Performance Analysis

Baseline data will be reported in March 2003 to support setting targets.

New Freedom Initiative Priority Area

2.4 Program Title: Best Practices: SAMHSA's National Mental Health Information Center (formerly Knowledge Exchange Network)

Performance Goals *Strategic Goal: Effectiveness*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase number of information requests from all sources. (E, O)	FY 05: TBR 5/05 FY 04: TBR 5/04 FY 03: TBR 11/03 FY 02: 36,612 (12% decrease over previous year. See text) FY 01: 54,815 (5% increase) FY 00: 57,533 (10% increase) FY 99: 30,406 (10% increase) FY 98: 29,263 (10% increase) FY 97: 11,356 (10% increase)	FY 05: TBR 11/05 FY 04: TBR 11/04 FY 03: TBR 11/03 FY 02: 42,583 (3% increase) FY 01: 41,305 (21% decrease) FY 00: 52,252 (2% decrease) FY 99: 52,303 (89% increase) FY 98: 27,642 (3% increase) FY 97: 26,603 (158% increase) FY 96: Baseline 10,324	**HHS SP 3.5**
Total Funding:	**2005: $2,300** **2004: $2,300** **2003: $2,300** **2002: $2,201** **2001: $2,183** **2000: $1,428** **1999: $1,190** **1998: $1,158** **1997: $ 453**		

Program Description and Context

The goal of the National Mental Health Information Center (NMHIC) is to provide a user-friendly gateway to a wide range of information about mental health treatment and services to consumers, their families, the general public, policy makers, providers, and researchers. NMHIC provides information about CMHS' technical assistance centers; Federal, State, and local mental health agencies; other national clearinghouses and information centers; mental health organizations and professional associations; and consumer and family advocacy organizations. Information is critical to helping an estimated 44 million Americans who experience a mental disorder in any given year.

Performance Analysis

Measure 1: Increase number of information requests from all sources.

This measure is an important overall outcome goal for the program, particularly with the post trauma effects of 9-11. NMHIC proved to be an important resource after the terrorists attacks of September 11. The number of users for the NMHIC web site increased from 96,507 "hits" in August to 126,617 in September and 146,346 in October. Increases in performance reflect success in educating the public about treatment, reducing stigma and improving access to treatment resources.

FY 2002 saw an increase in publications distributed and web site contacts, and a decrease in information requests (phone and e-mail), meeting two of the three targets. Since most NMHIC documents are now available on line, web contacts are rising while phone and e-mail requests are leveling off. In FY 2003, all types of information requests will be combined into one measure. New baselines and targets will have to be set.

2.5 Program Title: Best Practices: Community Action Grants for Service Systems Change (CAG)

Performance Goals *Strategic Goal: Effectiveness*	*Targets*	*Actual Performance*	*Refer-ence*
1. Achieve Consensus to Implement the Exemplary Practice (O)	FY 05: 85% Consensus FY 04: 85% Consensus FY 03: 85% Consensus FY 02: 85% Consensus FY 01: 85% Consensus FY 00: 85% Consensus FY 99: 85% Consensus	FY 05: TBR 11/05 FY 04: TBR 11/04 FY 03: TBR 11/03 FY 02: 81% consensus FY 01: 85% consensus FY 00: 85% consensus FY 99: 90% consensus FY 98: Baseline: 60%	**HHS SP 3.5**
2. Successfully Implement the Exemplary Practice (O, E)	FY 05: 58% Implement FY 04: 56% Implement FY 03: 54% Implement FY 02: 52% Implement FY 01: 50% Implement FY 00: 50% Implement FY 99: Establish baseline	FY 05: TBR 11/05 FY 04: TBR 11/04 FY 03: TBR 11/03 FY 02: 92% implemented FY 01: 57% Implemented (Baseline) FY 00: Data Unavailable FY 99: Data unavailable.	
Total Funding:	**2005: $0** **2004: $0** **2003: $1,000** **2002: $6,592** **2001: $5,532** **2000: $4,589** **1999: $3,275** **1998: $3,129**		

Program Description and Context

Community Action Grants (CAG) fund community activities designed to build consensus around the adoption and implementation of an exemplary practices to improve services in States, territories and Native American reservations. Exemplary practices are determined by strict criteria that require the grantees to demonstrate that the proposed intervention is evidence based in community or clinical settings. A second phase of the grant program supports implementation of the selected best practice. Areas addressed include case management; psychosocial rehabilitation; consumer/family/community empowerment; cultural competence; integrated substance abuse/mental illness and other treatment models; police training; jail diversion; outreach, screening and intervention for children; supported education and employment for adults; systems of care; and transitional services for young adults with mental illness.

Performance Analysis

Measure 1: Achieve Consensus to Implement the Exemplary Practice

Measure one was narrowly missed. This measure supports an important component of the grant program. Program needs at least two measurement points to determine whether a corrective action is warranted.

Measure 2: Successfully Implement the Exemplary Practice

The target for Measure 2 was exceeded. This measure supports an important compone nt of the grant program, the implementation of exemplary practices that have b Program needs at least two measurement points to determine whether a corrective action plan is needed.

HIV/AIDS and Hepatitis C Priority Area

2.6 Program Title: Targeted Capacity Expansion: HIV/AIDS Minority Mental Health Services

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of clients served (E, O)	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: Establish baseline	FY 05: TBR 10/05 FY 04: TBR 12/04 FY 03: TBR 12/03 FY 02: 338	**HHS SP 3.5**
2. Increase the percentage of clients with individual treatment plans within 4 weeks of being designated a client (E,O)	FY 05: dropped FY 04: dropped FY 03: TBR 10/02 FY 02: Establish baseline (New measure)	FY 05: NA FY 04: TBR 12/04 FY 03: TBR 12/03 FY 02: TBR 7/03	
Total Funding:	**2005: $9,600** **2004: $9,600** **2003: $9,600**		

Program Description and Context

The HIV/AIDS Minority Mental Health Services is a five-year grant program to increase capacity to provide culturally competent mental health treatment services to individuals and communities of color living with HIV/AIDS, within a sustained continuum of services in community-based environments. The program will also identify types and frequency of mental health treatment services utilized by different groups, and pinpoint the of types of mental health treatment providers needed in both traditional and non-traditional environments. The program specifically targets African American, Latino/Hispanic, and other racial and ethnic minority populations. The new grantees reflect a diverse range of service providers, including grassroots and indigenous community-based organizations.

Performance Analysis

Measure 1: Increase the number of clients served (E, O)

This is an important outcome measure for the program consistent with the program goal. Grantees will monitored to ensure that appropriate performance is achieved.

Measure 2: Increase the percentage of clients with individual treatment plans within 4 weeks of being designated a client

The new measure more accurately reflects the intent of the program and is a better indicator of success. The measure reflects whether the program is addressing the client's needs in a timely and appropriate manner. Data is being collected to set targets in early FY04.

Programs with Separate Budget Lines

Children's Priority Area

2.7 Program Title: Comprehensive Community Mental Health Services for Children and Their Families

Performance Goals	*Targets*	*Actual Performance*1	*Refer-ence*
1. Increase in number of children receiving services (E,O) (New Measure in 2003)	FY 05: 17,700 FY 04: 16,800 FY 03: baseline 8946 FY 02: Increase by 10% to 252 FY 01: Establish Baseline	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: 306 FY 01: Baseline: 229	**HHS SP 3.5** **HP 18-07, 18-10**
2. Increase interagency collaboration: Percentage of case records that reflect	FY 05: 60%	FY 05: TBR 10/05	

cross-agency treatment planning will increase (E, O)	FY 04: 60% FY 03: 60% FY 02: Maintain 50% increase (to 60%) FY 01: 50% Increase (to 60%) (Was 10%) FY 00: Maintain 10% increase FY 99: 10% increase FY 98: 5% increase	FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: 62.4% (*n* = 202) FY 01: 62.3% (*n* = 141) FY 00: 60.5% (*n* = 150) FY 99: 58% (*n* = 57) FY 98: 48.9% FY 97 Baseline: 40%	
3. Decrease utilization of inpatient facilities at 12 months (E, O)	FY 05: -3.00 days FY 04: -3.00 days FY 03: -3.00 days (Was Maintain 43% decrease; see narrative) FY 02: Establish new baseline (Was Decrease by 43%; see narrative) FY 01: Decrease by 40% (to 159) (Was 20%) FY 00: Maintain 20% decrease FY 99: Decrease by 20% FY 98: Decrease by 10%	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: -2.95 (*n* = 609), new baseline FY 01: 152 (*n* = 69) FY 00: 149 (*n* = 62) FY 99: 144 (*n* = 58) FY 98: 143.3 (*n* = 31) FY 97 Baseline: 265 days	
4. Improve children's outcomes: (E,O) (a) Increase percentage of children attending school 75% or more of the time after 12 months	FY 05: 80% FY 04: 80% FY 03: 17% increase (was 18%) (82.6%) FY 02: Maintain 18% increase (82.6%) FY 01: 18% increase (to 82.6%) (Was 10%) FY 00: Maintain 10% increase FY 99: 10% increase FY 98: 5% increase	FY 05: FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: 76.7% (*n* = 3,407) FY 01: 80% (*n* = 2,344) FY 00: 82% (*n* = 2,140) FY 99: 88.9% (*n* = 1,980) FY 98: 78.8% (*n* = 964) FY 97 Baseline: 70%[2]	
(b) Increase percentage of children with no law enforcement contacts at 12 months	FY 05: TBR 10/04 FY 04: TBR 10/03 FY 03: 47% FY 02: Establish new baseline (see narrative FY 01: 43% increase (to 67.2%) (Was 57%)	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: 46.5% (*n* = 142), new baseline FY 01: 44% (*n* = 463) FY 00: 44% (*n* = 293) FY 99: 43% (*n* = 281)	

	FY 00: Maintain at 57% FY 99: 57% increase FY 98: 52% increase	FY 98: 54.8% (*n* = 129) FY 97 Baseline: 47%[1]	
Total Funding:	**2005: $106,700** **2004: $106,700** **2003: $98,100** **2002: $96,459** **2001: $91,645** **20 00: $82,763** **1999: $77,909**		

[1]Baseline figure was computed after 6 months in services.

Program Description and Context

The Children's Mental Health Services Program supports the development of comprehensive community-based care for children and adolescents with serious emotional disorders. The program also supports the families of these youth. The main focus of the program is on developing systems of care to help address an estimated 21% of children in the United States who have a diagnosable mental or addictive disorder. Currently two-thirds of these children are not expected to receive mental health services. Further, at least one-third of children ages 12-21 who are served through the CMHS-funded systems of care appear to have dual mental and substance use problems. Findings from the National Evaluation suggest that the Program's unique approach especially benefits dual-diagnosed children.

This program primarily supports SAMHSA's Capacity goal. The program also provides strong support to the Effectiveness goal through the implementation of best practices, and its Accountability goal through its strong evaluation component.

Performance Analysis

The program uses unique strategies to achieve performance on its measures. Program funds are available through competitive cooperative agreements to States, political subdivisions of States, Territories, and Indian Tribes or tribal organizations. Funds are used to build on the existing services infrastructure so that the array of services required to meet the needs of the target population is available and accessible. Grants are limited to a total of 6 years, with an increasing non-Federal matching requirement over the term of the award to promote sustainability of the local systems of care beyond the grant period. It is estimated that over 18 of the first 22 grant communities initially funded in fiscal years 1993 and 1994 have continued to be sustained as service delivery systems since the federal program funds ended in fiscal years 1999 and 2000.

From 1993-2002, CMHS has funded grants in 43 States, and provided services to approximately 54,343 children. The program has served children in 274 of the 3,142 counties in the United States.

Long-Term Goals

The Children's Mental Health program has developed several preliminary long-term goals addressing clinical outcomes, sustainability, and cost-effectiveness:

- By FY 2010, 60 percent of grantees and cooperative agreements will exceed a 30 percent improvement in behavioral and emotional symptoms among children receiving services.
- By FY 2010, 80 percent of systems of care will continue to be sustained at least throughout the first five years after Federal funding has ended
- By FY 2010, 50 percent of grantees and cooperative agreements in their third to sixth year of funding will exceed a 5 percent decrease in Federal costs per child.

Measure 1: Increase in number of children receiving services (New Measure in 2003)

This measure is a good indicator of overall outcome performance for the program. Beginning in FY 2003, this measure will reflect total number of children served across sites, rather than average number per grant. Extensive data collected from grantees through national evaluation For Measure 1 for 2002, the target of a 10% increase in the average number of children served per grant was significantly exceeded. [This measure is used as a gross indicator of the service capacity of system-of-care communities that have been funded for at least three years.] These data are especially critical for identifying grant communities that are significantly under the average in order to provide targeted technical assistance.

Measure 2: Percentage of case records that reflect cross-agency treatment planning will increase

This measure reflect an important goal of the program. Two of the three targets for of interagency collaboration (Measure 2), including percentage of referrals from juvenile justice programs and percentage of case records that reflect cross-agency treatment planning, were exceeded. The indicator of percentage of referrals from non-mental health agencies for mental health services missed the target by approximately two percentage points. It appears that there may have been a slight decrease in referrals from the child welfare and education systems. To address this decrease, as well as to maintain an emphasis on interagency collaboration, the program has hired senior advisors in the areas of child welfare, education, juvenile justice and primary care to provide technical assistance to system-of-care communities.

In Measure 3: Decrease utilization of inpatient facilities at 12 months

This is an important goal for the program as success in community placement from in-patient settings and decreased need for in-patient care indicates that systems of care are working to support patients in the community. Utilization of inpatient/residential treatment at 12 months is now computed differently. In prior years, this measure included only children who already had a history of inpatient or residential care. These children represented only 5% of the children served by the program. Beginning this year, this measure was re-defined to document only the

changes in service use among the entire population of children served across the program's system-of-care communities. Also, the sample of children for this measure will no longer be a cumulative sample across grant years, but will represent the sample of children for whom the CMHS evaluation contractor had received information on 12-month assessments conducted during a one-year period, specifically from 7/1/01 to 6/30/02. Further, with this measure, as with second indicator of Measure 4, these changes result in establishing a new baseline for this measure in FY 2002 and the revision of targets for future years. The changes also explain the significant difference in the number of days between the one established for FY 2002 and those reported in previous fiscal years.

Measure 4: Improve children's outcomes:

(a) Percentage of children attending school 75% or more of the time after 12 months will increase

(b) Percentage of children with no law enforcement contacts at 12 months will increase

This is an important measure of success of the child in the community and reflects on the development of systems of care. For the indicator (a), the target was not met. It is possible that the population of children for whom outcomes were reported in FY 2002 had greater mental health needs than those in previous years. A population with greater mental health needs would also be expected to have greater challenges with school attendance.

For indicator (b), , was computed differently in FY 2002. As with Measure 3, in prior years, this measure included only children who have law enforcement contacts at entry rather than the entire population of children with serious emotional disturbance who are served in the program's systems of care. Beginning this year, this measure will be re-defined so that any changes in contacts with law enforcement can be assessed for the entire population of children served across the program's grant communities. Also, the sample of children for whom the CMHS evaluation contractor had received information on 12-month assessments conducted over a one-year period, from 7/1/01 to 6/30/02. These change result in establishing a new baseline for this measure and revising targets for future years.

New Freedom Initiative Priority Area

2.8 Program Title: Protection and Advocacy for Individuals with Mental Illness

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of complaints of abuse that will be addressed (E, O)	FY 05: 8,000 FY 04: 8,000 FY 03: 8,000 FY 02: 15,500 FY 01: 11,100 FY 00: 9,650 FY 99: 9,000	FY 05: TBR 7/06 FY 04: TBR 7/05 FY 03: TBR 7/04 FY 02: TBR 7/03 FY 01: 4,576 FY 00: 6,754 FY 99: 8,147 FY 98: 8,687	**HHS SP 3.5**

		FY 97: Baseline: 8,360	
2. Increase the number attending public education/constituency training and public awareness activities (E,O)	FY 05: 21,000,000 FY 04: 20,900,000 FY 03: 20,800,000 FY 02: 20,700,000 FY 01: 20,600,000 FY 00: New Baseline	FY 05: TBR 7/06 FY 04: TBR 7/05 FY 03: TBR 7/04 FY 02: TBR 7/03 FY 01: 22,951,431 FY 00: 20,529,374* FY 99: 162,214 FY 98: 230,343 FY 97: Baseline: 150,916	
3. Increase the percentage of substantiated incidents of abuse, neglect, or rights violations reported to State P&A systems that are favorably resolved (O)	FY 05: 80% FY 04: 80% FY 03: Increase to 80% FY 02: Increase to 77% FY 01: Increase to 76% FY 00: Maintain at 75% FY 99: NA	FY 05: TBR 7/06 FY 04: TBR 7/05 FY 03: TBR 7/04 FY 02: TBR 7/03 FY 01: 88% FY 00: 84% Average FY 99: Baseline: 75%	
Total Funding:	**2005: $32,500** **2004: $32,500** **2003: $33,770** **2002: $32,500** **2001: $30,000** **2000: $24,903** **1999: $22,949**		

Program Description and Context

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program provides formula grant awards to support protection and advocacy (P&A) systems designated by the governor of each State and the territories, and the Mayor of the District of Columbia. State P&A systems monitor facility compliance with respect to the rights of individuals to ensure the enforcement of the Constitution and federal and State laws. Facilities monitored include public and private residential care and treatment facilities and non-medical community-based facilities for children and youth. The program primarily supports SAMHSA's Capacity goal by expanding the availability of protection and advocacy services. The program directly supports the Seclusion and Restraint priority area as well as the New Freedom Initiative priority area. The expanded facility reporting required by the Children's Health Act of 2000 appears to have resulted in more P&A's having to utilize legal remedies to gain access to clients, facilities and records, as they attempt to investigate incidents of seclusion, restraint and related deaths. The program served 17,620 people in FY 2001

The current SAMHSA Annual PAIMI Program Performance Report (PPR) measures will expire in November 2003. New ones are being developed. The new measures will improve assessment of P&A system program priorities and services to improve the quality of life for persons with serious mental illness and their family members.

Performance Analysis

Measure 1: Increase the number of complaints of abuse that will be addressed

This measure reflects an important outcome of the program. State P&A systems experienced a decrease in the number of complaints of abuse addressed, missing the FY 2001 target. This decrease is believed to have occurred because State P&A systems are addressing systemic changes that affect groups of clients–for example, working with hospitals where several individuals may have registered complaints. This type of work represents a more economical use of resources. The targets for FY 03 and 04 have been revised downward to reflect this reality.

Measure 2: This measure reflects an important outcome of the program. Increase the number attending public education/constituency training and public awareness activities

A new baseline has been set. Future targets have been reset. Targets are set conservatively as several states produce significant variability in the data.

Measure 3: This measure reflects an important outcome of the program. Increase the percentage of substantiated incidents of abuse, neglect, or rights violations reported to State P&A systems that are favorably resolved

The program substantially exceeded its target for increasing the percentage of substantiated incidents that are favorably resolved.

Homelessness Priority Area

2.9 Program Title: Projects for Assistance in Transition from Homelessness (PATH)

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
1. Number of persons contacted. (O)	FY 05: 147,000 FY 04: 147,000 FY 03: 137,000 FY 02: 132,000 FY 01: 124,000 FY 00: 117,000 FY 99: 102,000	FY 05: TBR 7/07 FY 04: TBR 7/06 FY 03: TBR 7/05 FY 02: TBR 7/04 FY 01: TBR 7/03 FY 00: 109,000 FY 99: 123,000 FY 98: 115,000 FY 97: 105,000 FY 96: Baseline: 105,000	**HHS SP 3.5**
2. Increase percentage of participating agencies that offer outreach services (O)	FY 03: Measure dropped FY 02: 88% FY 01: 84% FY 00: 80% FY 99: 70%	FY 03: Measure dropped FY 02 TBR 7/04 FY 01: TBR 7/03 FY 00: 88% FY 99: 88% FY 98: 86% FY 97: 87%	

3. Increase percentage of persons contacted who become enrolled (O)	FY 05: 46% FY 04: 42% FY 03: 39% FY 02: 37% FY 01: 35% FY 00: 33% FY 99: 30%	FY 05: TBR 7/07 FY 04: TBR 7/06 FY 03: TBR 7/05 FY 02: TBR 7/04 FY 01: TBR 7/03 FY 00: 42% FY 99: 36% FY 98: 37% FY 97: 41% FY 96: Baseline: 41%	**HP –18-3**
Total Funding:	**2005: $50,100** **2004: $50,100** **2003: $43,073** **2002: $39,855** **2001: $36,855** **2000: $30,883**		

Program Description and Context

The Projects for Assistance in Transition from Homelessness (PATH) formula grant program, established in 1991, primarily supports SAMHSA's Capacity goal by expanding the availability of services to homeless individuals with serious mental illnesses. The program distributes Federal funds to each State, the District of Columbia, and certain US territories to support a broad array of individualized services to this vulnerable population. The program directly supports the Secretary's Initiative as well as SAMHSA's Homelessness priority area.

The goal of the PATH program is to provide services that will enable homeless persons with serious mental illnesses to be placed in appropriate housing and to receive formal mental health treatment and other resources to improve their mental health functioning. The statute specifies the range of services that may be supported by States under the program: outreach; screening and diagnostic services; habilitation and rehabilitation; community mental health services; alcohol or drug treatment (for those with co-occurring disorders); staff training; case management; supportive and supervisory services in residential settings; and referrals for primary health care, job training, and education. Some housing services may be provided as well. States have considerable flexibility in designing programs, and are required to match funds with one dollar for every three dollars received in Federal funds. In recent years, State and local support has been more than double the amount required by the match.

Performance Analysis

Long-Term Goals

The PATH program was reviewed by OMB through the PART process in 2002. The program received a "moderately effective" score. The PART process also facilitated PATH implementing several specific, ambitious long-term goals and is currently collecting annual data that record its annual progress in meeting them (goals and targets are preliminary):

- **$** Increase the percentage of contacted homeless persons with serious mental illnesses who are enrolled in services (Five year target: 47%; FY 2000 actual: 42%)
- **$** Increase the percentage of enrolled homeless persons with serious mental illnesses who receive case management services (Five year target: 98%; FY 2000 actual: 95%)
- **$** Increase the percentage of enrolled homeless persons with serious mental illnesses who receive community mental health services (Five year target: 75%; FY 2000 actual: 61%)
- **$** Maintain the cost for enrolling a person into services. (E)

Measure 1: . Number of persons contacted.

This is a standard outcome measure of program performance. The target was not met for 2001. As data reporting methods improve, the reported number of persons contacted has become more accurate. Because the numbers reported in previous years were based on less accurate data and were likely overstated, the number reported may be a more accurate reflection of the actual count rather than an actual decline. The program is taking several corrective action steps to improve the accuracy of reported data, including improvements in software, strengthened verification of questionable numbers, and increased training of State and local PATH-funded staff.

Measure 2: . Increase percentage of participating agencies that offer outreach services

The percentage of agencies offering outreach services reached 88%, exceeding the target of 80%. Measure to be dropped after reporting final data.

Measure 3: . Increase percentage of persons contacted who become enrolled

This is an important outcome measure of program performance. Despite the decrease in the number of persons contacted, the actual number of individuals enrolled in services increased in FY 2000 (from 44,280 to 45,780). The percentage of persons contacted who actually enrolled in services rose from 36% in FY 1999 to 42% in FY 2000, considerably exceeding the target of 33%.

Data Note: Most States award their annual PATH funds late in the fiscal year. Accordingly, there is an unavoidable data lag as States collect and compile data prior to submitting the data to SAMHSA. It is also important to note that this data lag also delays the impact of any budget increase or decrease on performance data.

New Freedom Initiative Priority Area

2.10 Program Title: Community Mental Health Services Block Grant

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
1. SAMHSA Core Measures:			**HHS SP 5, 3.5**

a. Increase % of adults with serious mental illness who are employed. (O)	FY 03: Measure dropped FY 02: 20.9% FY 01: 20.8% FY 00: 17.5% FY 99: Establish baseline	FY 03:Measure dropped FY 02: 24.7% FY 01: 20.4% FY 00: 20.8%* FY 99: 17.3%* (17 States)	**HP 18-4**
b. Increase % of adults with serious mental illness who are living independently. (O)	FY 03: Measure dropped FY 02: 67.7% FY 01: 67.6% FY 00: 66.7% FY 99: Establish baseline	FY 03: Measure dropped FY 02: 70.1% FY 01: 68.1% FY 00: 67.6%* FY 99: 66.5%* (16 States)	
c. Decrease % of adults with serious mental illness who have had contact with the criminal justice system. (O)	FY 03: Measure dropped FY 02: 6.0% FY 01: 6.0% FY 00: 5.3% FY 99: Establish baseline	FY 03: Measure dropped FY 02: 7.5% FY 01: 6.4% FY 00: 7.4%* FY 99: 5.4%* (11 States)	
d. Increase % of children with serious emotional disturbance who attend school regularly. (O)	FY 03: Measure dropped FY 02: 65.8% FY 01: 45.2% FY 00: 65.8% FY 99: Establish baseline	FY 03: Measure dropped FY 02: 65.8%. FY 01: 54.3% FY 00: 44.6%* FY 99: 65.6%* (9 States)	
e. Increase % of children with serious emotional disturbance who reside in a stable environment. (O)	FY 03: Measure dropped FY 02: 60.8% FY 01: 60.7% FY 00: 50.6% FY 99: Establish baseline	FY 03: Measure dropped FY 02: 30.8% FY 01: 70.8% FY 00: 60.1%* FY 99: 50.4%* (6 States)	
2. Decrease % of children with serious emotional disturbance who have had contact with the juvenile justice system (O)	FY 03: Measure dropped FY 02: 6.3% FY 01: 6.4% FY 00: 14.2% FY 99: Establish baseline	FY 03: Measure dropped FY 02: FY 01: 12.3% FY 00: 6.4%* FY 99: 14.3%* (11 States)	
3. Number of people served (O)	FY 05: 218,000 FY 04: 223,000 FY 03: 227,500 FY 02: Establish baseline	FY 05: TBR 12/05 FY 04: TBR 12/04 FY 03: TBR 12/03 FY 02: baseline 234,500	
Total Funding:	**2005: $433,000** **2004: $433,000** **2003: $437,140** **2002: $433,000** **2001: $420,000** **2000: $356,000** **1999: $288,816**		

Program Description and Context

The Community Mental Health Services Block Grant addresses SAMHSA's goal of increasing capacity as well as the goal of promoting effective services. The Program assists the 59 eligible and participating States and Territories in moving care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) from costly and restrictive inpatient hospital care to the community. States have considerable latitude in determining how they will use funds. The program also provides strong support to the Effectiveness goal through the implementation of best practices. The Block Grant program supports multiple SAMHSA priority areas, including co-occurring disorders; children and families; and the New Freedom Initiative.

The closing of psychiatric hospitals through the 1980's and 1990's has not generally been matched by increased availability of community services. In the community, individuals can receive the necessary treatment and supports to live more fulfilling and productive lives. However, as stated in the recent Surgeon General's report, "In the United States in the late 20th century, research-based capabilities to identify, treat, and in some instances, prevent mental disorders are outpacing the capacities of the existing service system to deliver mental health care to all who would benefit from it." Further, there is also data that shows that significant percentages of welfare beneficiaries have untreated mental illness preventing them from finding and keeping employment.

States vary widely in their ability to report mental health data depending upon data infrastructure and reporting capacity. Since its inception, CMHS has worked with States to improve data collection and reporting. Efforts have included working to develop performance measures, participant counts, and other program data. Some of these measures were piloted in the 16-State Project, which was designed to develop uniform data and unduplicated counts of people served by the State Mental Health Authority. Core measures for the Block Grant program were implemented on a voluntary basis in an effort to capture the data available at that time. Despite efforts to establish standard data definitions, these were not available through FY 2001. Consequently, the data reported are not meaningful when aggregated or comparable across States or across time. These data issues have led to difficulty in quantitatively demonstrating the efficiency and effectiveness of the Block Grant program. In FY 2002, the Block Grant application contained a set of OMB-approved performance measures with more precise definitions, in an effort to obtain more uniform data.

The Children's Health Act of 2000 included a requirement to provide $6 million in PRNS funding for the enhancement of the States' and Territories' data infrastructure. Forty-seven States have now received grants to improve their ability to develop data standards for uniform, comparable, high-quality statistics on mental health services administered with Block Grant funds. In FY 2004, $11 million is proposed for this purpose, an increase of $5 million.

It is expected that these grants, combined with refinement of the results of the 16-State Project, will assist States in developing their infrastructure capacities to begin reporting uniform data as part of the block grant application. The Act further requires the Secretary, in conjunction with the States and other interested groups, to develop plans for creating more flexibility and

accountability for States in the use of mental health and substance abuse block grant funds based on outcome and other performance measures.

In responding to this mandate, CMHS has worked with the States to develop three goals for performance measurement that describe the State Mental Health Authority (SMHA) Public Mental Health System, develop continued quality improvement (CQI) benchmarks for the SMHA Public Mental Health System, and improve the performance of the SMHA Public Mental Health System.

Current measures will be replaced by Performance Partnership Measures in 2005. Further information about the strategies and implementation plan for the Performance Partnership Grants, appears in Appendix A.5. It is expected that all of these efforts will improve States' ability to report data on mental health services and recipients.

Efficiency Measures: Evidenced Based Practices. In order to operationalize this measure, a pilot study will be conducted in FY05 on the relationship between Evidence Based Practices and cost for baseline data.

Long-Term Measures

CMHS is in the process of finalizing these measures and will provide them in the OMB submission.

The third year of the 16-State Project referenced in Measure 2 has been completed. Thirty-two performance indicators were piloted in 16 States. Preliminary data, including hospital readmission rates, penetration/utilization rates, and consumer perceptions, are available at http://www.mhsip.org/sixteenstate/index.htm.

Performance Analysis

Measure Set One: See Performance Table for indicators a – e

All of these outcome measures assess important dimensions of program performance, but are being dropped in favor of changed measures. The main strategy of the CMHS BG program is to provide a funding stream to support States and Territories in the development of comprehensive, community-based mental health systems of care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Two essential statutory components of the MHBG are the planning requirements and the establishment and maintenance of the State Mental Health Planning Council. The block grant is used as a flexible funding source to enable these individuals with SMI and SED to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

a. Increase % of adults with serious mental illness who are employed. For FY 2002 actual performance was 24.7% which exceeded the target of 20.9%.

b. Increase % of adults with serious mental illness who are living independently. For FY 2002 actual performance was 70.1% which exceeded the target of 67.7%.

c. Decrease % of adults with serious mental illness who have had contact with the criminal justice system. For FY 2002 actual performance was 7.5% which did not meet the target of 6.0% This small difference can be attributed to the change in which states report data from year to year.

d. Increase % of children with serious emotional disturbance who attend school regularly. For FY 2002 actual performance was 68% which exceeded the target of 65.8%.

e. Increase % of children with serious emotional disturbance who reside in a stable environment. For FY 2002 actual performance was 30.8% which did not meet the target of 60.8%. This is a difficult measure in that there is little consistency in the States who report data from year to year. For example, of the 8 States reporting in FY 2001, only two subsequently reported in FY 2002. Seven States reported in FY 2002. Measure dropped for FY 2003.

Measure 2: Decrease % of children with serious emotional disturbance who have had contact with the juvenile justice system

Measure 3: Number of people served. FY 2002 baseline established at 234,500 people served.

A measure of the number of people served has been added to assess the impact of the program. Because States currently are unable to report exact utilization numbers - the number of persons serviced by the MHBG funds is estimated. CMHS utilizes an estimate based on the average dollars used by Medicaid clients for outpatient care. Because the average Medicaid claimant cost is expected to rise over the next two years while the MHBG budget remains level, the number of clients served by the MHBG program is expected to decline somewhat from the FY 2002 baseline.

Substance Abuse Prevention

The mission for the Center of Substance Abuse Prevention is to decrease substance use and abuse by bringing effective prevention to every community. Data from SAMHSA's National Survey on Drug Abuse and Health, show that the need for drug treatment by 2020 will grow by 57 percent if the current rate of initiation of marijuana continues at its 1995 level of about 2.5 million new users. Census data show that in the 15-20 age group, which exhibits the highest levels of substance abuse, is projected to grow by about 11%, or 2.3 million, over the next ten years. Current research shows that science based substance prevention is effective in not only in preventing youth from initiating in the first place, but also in reducing the numbers who become dependent.

CSAP programs support all three SAMHSA goals: accountability, capacity and effectiveness, and also support many of the eleven SAMHSA program priority areas. As the lead Federal organization in the nation's substance abuse prevention efforts, CSAP's main objectives are to increase substance abuse prevention programming throughout the United States; to support the effective implementation of effective programs in communities, and to promote the use of performance measures and evaluation tools by substance abuse prevention providers. These objectives are at the core of SAMHSA's new **Prevention Framework,** which is a strategic approach to prevention that SAMSHA has developed and is beginning to implement in FY 2003. The Prevention Framework has two primary components: a basic set of program elements that must be in place in order to facilitate the improvement of prevention activities and services in communities; and a five step methodology that communities can use to implement change. The Prevention Framework therefore guides not only the reconfiguration of SAMHSA's programs but also the process of effecting change at the community level.

This report includes all current CSAP programs. These programs are:

2.11 Targeted Capacity Expansion: State Incentive Grants
2.12 Best Practices: National Clearinghouse for Alcohol and Drug Information
2.13 Best Practices: National Public Education Efforts
2.14 Best Practices: Starting Early Starting Smart
2.15 Best Practices: Family Strengthening
2.16 Best Practices: Center for the Prevention of Application Technologies
2.17 Best Practices: Community-Initiated Prevention Intervention Studies
2.18 Targeted Capacity Expansion: Substance Abuse Prevention and HIV Prevention Initiative
2.19 Synar Amendment
2.20 20% Substance Abuse Prevention and Treatment Block Grant Prevention Set-Aside

Programs of Regional and National Significance
Prevention and Early Intervention Priority Area

2.11 Program Title: Targeted Capacity Expansion: State Incentive Grants (SIGs)

Performance Goals Strategic Goal: Capacity	*Targets*	*Actual Performance*	*Refer - ence*
1. Increase State collaboration rating in the following areas: (a) prevention service delivery (b) prevention legislation/ policies (c) use of prevention related resources	FY 05: TBR 9/03 FY04: 50% increase over baseline (a=84%, b=42 %, c=23% FY 03: 40% increase over baseline (a = 79%, b = 40%, c = 21%) FY 02: 35% increase over baseline (a = 76%, b = 38%, c = 20%) FY 01: 30% increase over baseline (a = 73%, b = 36%, c = 19%) FY 00: 25% increase in collaboration for (a), (b) & (c) (a = 70%, b= 35%, c=19%)	FY 05: TBR 9/06 FY04:TBR 9/05 FY 03: TBR 9/04 FY 02: TBR 9/03 FY 01: (a) 57% (b) 52% (c) 67% FY 00: (a)76.5% (b)52.9% (c) 64.7% FY 98: Baseline (a) 56% (b) 28% (c) 15%	**HHS SP 1**
2. Decrease past month substance use for youth 12-17 (O)	FY 05: TBR 9/03 FY04: 6.3% (36% decrease from revised baseline) FY 03: 6.4% (35% decrease from baseline) FY 02: 7.1% (28% decrease from baseline) FY 01: 7.7% (22% decrease from baseline) FY 00: 8.4% (15% decrease from FY 98 baseline)	FY 05: TBR 9/06 FY04: TBR 9/05 FY 03: TBR 9/04 FY 02: TBR 9/03 FY 01: 10.8% FY 00: 9.7% FY 99: 1999 NHS data: 9.8 (national data; revised from 9.1% by SAMHSA). See text for discussion. FY 98 Baseline: 1998 NHS data - 9.9% (national)	**HP – 2-26-9, 26-10, 26-15**
3. Increase the number of science-based programs being implemented by local sub-recipients in SIG states (O, E)	FY 05: TBR 9/03 FY04: 1,400 SIG programs will be science-based) FY 03: 1,017 SIG programs will be science-based)	FY 05: TBR 9/06 FY04: TBR 9/05 FY 03: TBR 9/04	

	FY 02: 977 SIG programs will be science-based FY 01: At least 50% of all SIG funds for sub-recipient programs will be devoted to science-based programs FY 00: Establish baseline	FY 02: TBR 9/03 FY 01: 74% (818) programs are science-based. Approximately 85% of funds are devoted to science based programs. FY 00: 797 programs are science based. FY01: $53.55 million FY00: $48.45 million	
Total Funding:	**2005: $64,500,000** **2004: $54,700,000** **2003: $60,500,000** **2002: $60,600,000** **2001: $60,600,000** **2000: $61,652,000** **1999: $61,652,000** **1998: $55,993,000** **1997: $15,000,000**		

Program Description and Context

State Incentive Grants (SIGs) are CSAP's Targeted Capacity Expansion mechanism for building prevention capacity. State and territories eligible for the Substance Abuse Prevention and Treatment Block Grant (60 entities) are also eligible to receive SIG funding. The SIG program improves States' capacity to address prevention needs by funding States to develop comprehensive, State-wide prevention systems. These systems enable States to better utilize prevention resources, implement effective prevention program models, and coordinate prevention among different agencies and funding streams. Eighty-five percent of program funds provided under the SIG grants are channeled to local community-based and faith-based organizations, community partnerships and coalitions, workplace-based prevention and early intervention programs, local governments, schools, and school districts. A total of 43 States will have received a SIG award by FY 2003.

The SIG program is changing the face of prevention in communities across the country by supporting the implementation of a wide array of prevention programs that have been shown to be effective in preventing substance abuse among youth. In 2003, CSAP will fund an estimated 550 community-based organizations to implement or enhance substance abuse prevention programs. In 2002, CSAP funded an estimated 400 community-based organizations to implement or enhance substance abuse prevention programs. These organizations implemented more than 1,100 local prevention programs. An indicator of success is that the first five SIG States continue to operate the prevention programs initiated under the SIG, even though SIG funding has ended. In addition, many States are better leveraging their Block Grant funds by requiring that these funds also support science-based prevention programs.

Performance Analysis

Measure 1: Increase State collaboration rating in the following areas: (a) prevention service delivery (b) prevention legislation/ policies and (c) use of prevention related resources

This measure tracks performance in three important domains. For FY 2001, the SIG program continued to exceed its target in two of the three collaboration measures, prevention legislation/policies and use of prevention resources. The target for prevention service delivery was not met; largely because a number of newer SIGs were included in the measure, and collaboration on service delivery requires a great deal of collaboration and planning which newer programs require more time to achieve. The bar has now been set very high on the 3 measures and, given the ebb and flow of collaboration processes and the varying stages of development of newer SIGs, collaboration scores are expected to vary.

Measure 2: Decrease past month substance use for youth 12-17

This is a key outcome measure for the program. According to the National Survey on Drug Use and Health, 10.8% of youth aged 12-17 reported using a substance in the past month in 2000.

National substance abuse figures do not adequately reflect the impact of the SIG program, but this is best data source currently available to track this measure. To improve data, SIG States are in the process of developing State surveys. The State surveys will be especially helpful by allowing analysis at other levels (regional, local). States will report their State-, community-, and program-level usage data in their final reports to CSAP for use in the GPRA report. This is a major step forward in moving towards State level outcome performance measures. In addition, as new SIG cohorts have been funded, and data requirements have increased. The program-level outcomes are just becoming available as earlier cohorts of SIG-funded States analyze their 3-4 years of data.

Measure 3: Increase the number of science-based programs being implemented by local sub-recipients in SIG states

This measure is important in increasing the efficacy of prevention services. The FY 2001 target was met. Of programs, 818 (74%) were science-based, and about 85% of funds were devoted to these specific programs. In addition to these results on the measures, SIG States have been successful in identifying and leveraging prevention funds. Preliminary information shows that some SIG States have leveraged up to 10 times the federal grant amount through matching funds.

2.12 Program Title: Best Practices: National Clearinghouse for Alcohol and Drug Information (NCADI)

Performance Goals *Strategic Goal: Effectiveness*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase number of information requests (O,E)	FY 05: TBR 9/03 FY04: 290% increase FY 03: 280% increase FY 02: 270% increase (47,520 per month) FY 01: 260% increase (45,760 per month) FY 00: 245% increase over baseline (43,120 per month)	FY 05:TBR 10/05 FY04: TBR 10/04 FY 03: TBR 10/03 FY 02: 259% (45,587 per month) FY 01: 261% (45,886 per month) FY 00: 163% (41,239 per month) FY 99: 135% (40,285 requests/month) 59 percent of inquiries are made by phone; 3 percent by mail; and 2 percent by fax/in-person FY 98: 43 % increase (25,289 requests/month) Telephone: 14,437/month, Mail: 2887, E-mail: 6810, PREVLINE: 1155 FY 97 Baseline: 17,600 requests/month Telephone: 13,750 requests/month., mail: 2,750 requests/month; PREVLINE: 1,100	**HHS SP -1**
2. Maintain customer satisfaction	FY 05: TBR 9/03 FY04: 95% FY 03: 95% FY 02: 95% FY 01: 85% FY 00: 85%	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: 95% FY 01: 97.5% FY 00: 92% FY 99: Exceeded 90% FY 98:Exceeded 90% FY 97 Baseline: 85%	
Total Funding:	**2005: $7,000,000** **2004: $7,000,000** **2003: $7,000,000** **2002: $8,837,000** **2001: $7,000,000** **2000: $4,729,000** **1999: $2,023,000** **1998: $9,162,000**	Note: New customer satisfaction survey implemented in FY 00 resulted in revision of targets. See text for discussion.	

Program Description and Context

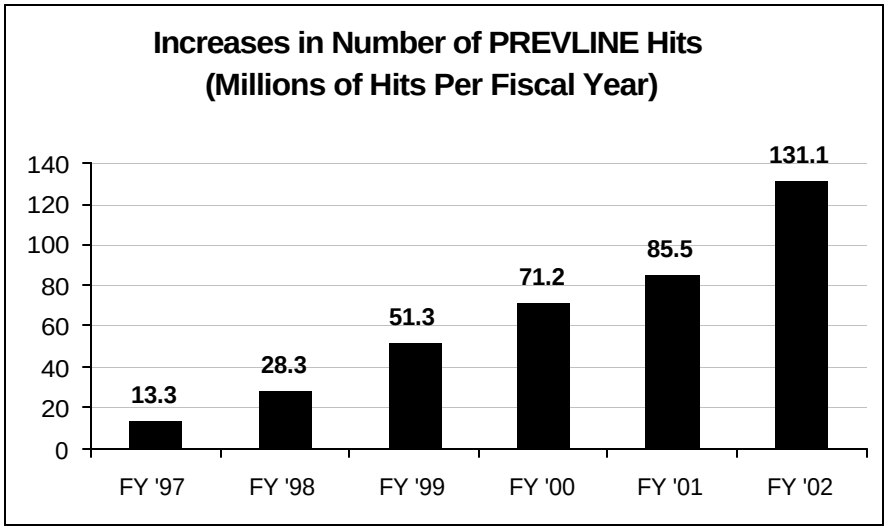
For the past 15 years, the National Clearinghouse for Alcohol and Drug Information has served at the Nation's single point of entry in the Federal government for comprehensive, customer-friendly information about substance abuse prevention, intervention, and treatment. NCADI operations have expanded significantly to meet the fulfillment needs of the ONDCP National Youth Anti-Drug Media Campaign, SAMHSA's targeted press efforts, CSAP's dissemination and application initiatives and highly targeted public education campaigns, CSAT's knowledge application initiative and public affairs efforts, and the dissemination efforts of NIAAA, NIDA, and the Department of Education.

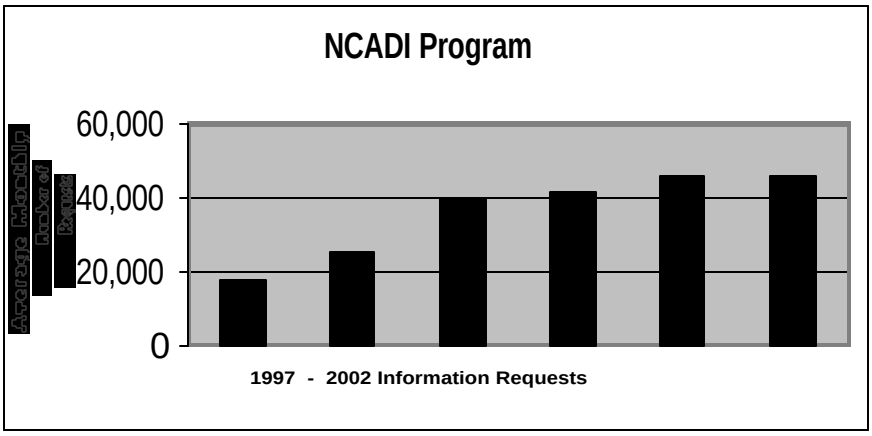
The Clearinghouse is a contracted program which exists to serve a wide variety of Federal dissemination needs, but its ultimate success is based on its ability to reach the consumers of SAMHSA and its Centers, the ONDCP, and other Federal partners. Achieving high levels of customer satisfaction across all tasks is a primary focus for the NCADI contract.

Performance Analysis

Measure 1: Increase number of information requests
This is an important overall program measure of a key outcome. Although the FY 02 target was missed, performance came within about 4% of the target. The slight decline in information requests can be explained by the following factors:

- **$** On average, CSAT Treatment Helpline calls represent nearly 50 percent of all calls to NCADI, which take more time and often do not result in an order for materials. This steady increase in treatment requests over the past 4 ½ years reflects a notable change in the public's information needs. The post-9/11 climate, the economic downturn, and CSAT's successful marketing of the Treatment Helpline have contributed to the marked increase in treatment calls over the past year.
- **$** Of those callers requesting materials, the Regional Alcohol and Drug Awareness Resource (RADAR) Network Centers have been requesting greater bulk quantities of materials at a time, hence fewer contacts.





Measure 2: Maintain customer satisfaction

Maintaining customer satisfaction is a key outcome the program is tying to achieve. The FY 02 target of 95% was met.

2.13 **Program Title: Best Practices: National Public Education Efforts**

Performance Goals: Strategic Goal: Effectiveness	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase media placements & media access: Radio newsline (O)	FY 05: TBR 10/03 FY 04: 65 million FY 03: 59.4 million FY 02: 33.2 million FY 01: 30.5 million FY 00: 28 million	FY 05: TBR 10/05 FY04: TBR 10/04 FY 03: TBR 10/03 FY 02: 78 million FY 01: 51.8 million FY 00: 28.5 million	**HHS SP -1**
2. Media placements (E)	FY 05: TBR 10/03 FY 04: 27,000 FY 03: 24,200 FY 02: 14,300 FY 01: 13,700 FY 00: 13,000	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: 27,750 FY 01: 20,000 FY 00: 13,350	
Total Funding:	**2005: $6,500,000** **2004: $7,200,000** **2003: $8,500,000** **2002: $8,837,000** **2001: $8,700,000** **2000: $6,860,000** **1999: $6,860,000** **1998: $6,300,000** **1997: $1,000,000**	Note: for all indicators, earlier performance was: FY 99: More than 100% over baseline FY 98: Significantly more than 100% over baseline FY 97 Baseline: 5 -15% response rate to media outreach efforts	

Program Description and Context

This program provides information and education resources to improve public awareness of substance abuse trends, their impact, and effective preventive interventions. This current set of program initiatives supports national efforts at various implementation phases; For example, the Reality Check Marijuana Public Education Initiative, the Girl Power! Campaign, and the SAMHSA/CSAP Hispanic/Latino Initiative are supported. New initiatives in development include the Fetal Alcohol Syndrome/Alcohol Related Birth Defects public education project, SAMHSA/CSAP & NIAAA "Tweens" Underage Drinking public health campaign, SAMHSA/CSAP & CDC Underage Drinking public health campaign, and the Governors' Spouses Initiative--The Leadership Project to Keep Children Alcohol Free.

Measure 1: Increase media access: Radio newsline

This is a key outcome and efficiency goal for the program. In FY 2002, the target for the Radio Newsline was substantially exceeded. The Newsline newsfeed service, made available via toll-free telephone lines and Web-based streaming audio, had an average monthly audience of 6.5 million listeners, for an estimated annual total of 78 million listeners. The target for FY 2002 listeners was only 33.2 million.

Twenty-six SAMHSA Radio Newsline reports were produced. The Newsline is promoted via broadcast fax. Information about each Newsline report reaches approximately 2,000 selected stations per month. SAMHSA Newsline reports are aired, on average, more than 1,000 times per week by radio stations across the country.

Measure 2: Media Placements

For FY 02, the target for Media Placements was substantially exceeded. Future targets have been set at a higher level.

Other indicators of success, not included as GPRA measures, are the number of hits and visitors on the various public education web sites. For example, the Reality Check marijuana public education website (www.health.org/reality) received 4,277,085 hits in FY 2001 and 6,080,337 hits in FY 2002 a 42 percent increase in FY 2002 as compared to FY 2001. In FY 2002 Reality Check won the WWW Health Awards - Bronze from The World Wide Web Health Awards, the Silver Inkwell Award, and the APC Web Development Excellence Award.

The youth component, ForReal.org, a website designed specifically for teens, received 3.1 million hits in FY 2001 and 7,455,807 hits in FY 2002, a 140.5 percent increase in FY 2002 as compared to FY 2001. ForReal won the CyberSitter Award - A site filtering award in February 2002 and the merit award in March 2002 from the World Wide Web Health Awards.

2.14 Program Name: Best Practices: Starting Early/Starting Smart: Early Childhood Collaboration Project

Performance Goals *Strategic Goal: Effectiveness*	*Targets*	*Actual Performance*	*Refer-ence*
1. SAMHSA and partners execute Memoranda of Understanding	FY 03: NA - Program over FY 02: Maintain MOU's in 5 sites with continuing services FY 01: 2 additional funders FY 00:Maintain 100%	FY 02: Target met all 5 MOU's Maintained FY 01: No additional funders were engaged (see text) FY 00: 100% FY 99: 100% FY 98 Baseline: 50% have MOUs.	**HHS SP -1**
2. Increase the following indicators: (O) a) physical health, b)behavior, c)social; and d) emotional functioning, language development	FY 03: NA - Program over FY 02: Maintain any positive program values FY 01: Additional 5% increase in the differential between intervention and control group reports across physical and behavioral measures. FY 00: a)Physical Health: 5% increase in the differential between intervention and control group reports of good health. b) Behavioral Health: 5% decrease in the mean rating for children on the Problem Behavior Sub-scales c) and d) Cognitive - 5% increase in the scores for receptive and expressive language.	FY 02 a) Physical Health: -+3.1% (positive result, target not met) b)Behavioral Health: +3.7% (positive result, but target not met) c)Cognitive-Receptive Language: +11.9% (positive result, target exceeded). d) Cognitive-Expressive Language: +2.5% (positive result, target exceeded). FY 01: a) Physical Health: -3.3% (negative result, target not met) b)Behavioral Health: +.04% (positive result, but target not met) c)Cognitive Receptive Language: +8.2% (positive result, target exceeded). d)Expressive language: No difference (target not met). FY 00: a) Physical Health: Less than 1% fro m comparison group; target not met. b) Behavioral Health:	

		Problem Behavior Sub-scales (parent ratings): difference between the intervention and the comparison was +3.0%* c)Cognitive: Receptive Language: +2.37% d) Expressive Language: +6.68%.* ***Preliminary data**	
		FY 98 a) Baseline Physical Health: 42.9% care givers report good /excellent FY 98 b)Baseline Behavioral Health: Mean 44.52 on Problem Behaviors Score, PKBS FY 98 c)Baseline Cognitive: Preliminary baseline data indicated differences of: Receptive language 8.08 Expressive language 8.50.	
Total Funding:	**2005: $0** **2004: $0** **2003 : $ 2,300,000** **2002 : $2,096,000** **2001 : Funded by CMHS** **2000: $7,422,000** **1999: $7,986,000** **1998: $8,277,000** **1997: $6,200,000**		

Program Description and Context

The goal of Starting Early/Starting Smart is to evaluate the effectiveness of integrated mental health and substance abuse prevention and treatment services for children ages birth to seven years and their families/care givers, in primary health care service clinics or early childhood service settings. The program has been carried out in collaboration with the Department of Education, the Health Resources and Services Administration, the Administration for Children and Families, and the private Casey Family Foundation. Grantees are located in Head Start program sites, child care or preschools, and primary care health clinics. Grants are awarded as cooperative agreements that support an integrated partnership, 12 community Grantees, and a Data Coordinating Center. Approximately 3,000 children and their families have been enrolled in the program. Data from two additional follow-up administrations will be collected in five sites. These data will provide findings on maintenance of positive program impacts.

This collaborative activity has led to a FY 2004 plan to fund a new Targeted Capacity Expansion program to build and/or strengthen the infrastructure in States and communities for an early intervention system tied to early childhood settings and primary health care.

Performance Analysis

Measure 1: . SAMHSA and partners execute Memoranda of Understanding

Additional funders were not engaged. However, 100% of the existing Federal and private partners have executed an MOU that specifies continued collaboration through FY 2002 for measure 1.

Measure 2: Increase the following indicators: a) physical health, b)behavior, c)social; and d) emotional functioning, language development

Measure 2: Final report indicates positive results for all measures, although only receptive language met the GPRA target.

SESS-P (prototypes) is the second cohort of SESS grants funded by CSAP. The SESS-P initiative is intended to enhance understanding of the lessons learned from the first generation of SESS grantees. This program is designed to obtain, develop and implement knowledge pertaining to the improvement of behavioral health services and service delivery to families with young children 0-7 whose lives are affected by substance abuse, domestic violence, family disruption and/or mental disorders.

2.15 Program Title: Best Practices: Family Strengthening Study (Incorporated Into the High Risk Youth Budget Line)

Performance Goals Strategic Goal: Effectiveness	*Targets*	*Actual Performance*	*Refer-Ence*
1. Sites will find positive change in factors associated with family communication skills by the end of the project. (O,E)	FY 05: Prg. Over FY 04: Cohort 3, Establish baseline (target expected to be 35% of sites) FY 03: Cohort 2, 65% of sites FY 02: Cohort 2, Establish baseline (target expected to be 35% of sites). FY 01: Cohort 1, 75% of sites FY 00: Cohort 1, Establish baseline	FY 05: Cohort 4 – TBR 10/05 FY 04: Cohort 3 - TBR 10/04 FY 03: Cohort 2 - TBR 10/03 FY 02: Cohort 2 Preliminary data: 22% of sites have reported positive change FY 01:Cohort 1- 60% of sites (Final report; see text for explanation) FY 00: Baseline date obtained from 47% of sites	**HHS SP -1**

Total Funding:	**2005: Prg. Over** **2004: $ 1,600,000** **2003: $ 3,800,000** **2002: $ 3,800,000** **2001: $3,800,000**		

Program Description and Context

The goal of the Family Strengthening Study is to help families and high risk youth by identifying best practices to determine: (1) factors for selection of the best evidenced-based model for specific populations; (2) the factors influencing decisions in adopting and implementing a family intervention model; and (3) evaluating which interventions continue to produce positive findings when culturally modified and replicated by community-based systems of care.

Grantees are expected to field test the intervention (within multiple settings, when applicable) and to graduate a minimum of thirty families in the local community through the program. Cohort 3 has an added emphasis on widespread implementation by sites to include different target groups. Cohort 3 study sites are expected to graduate a minimum of fifty families in an expanding service component to this program.

Performance Analysis

Measure1: Sites will find positive change in factors associated with family communication skills by the end of the project.

Measure tracks key program outcomes. Family communication variables in the measure consist of: 1) family relations, 2) family resilience, 3) family needs, 4) family conflict, 5) family cohesion, and 6) family attachment. The data for Cohort 1 were delayed because grantees found it more difficult to recruit and retain families than they had expected. Sixty percent of Cohort 1 sites reported positive changes according to this measure by March 2002, the scheduled date of reporting. The 60% that did report showed that average scores were statistically significantly increased for family relations and family resilience indicators, but decreased for family needs, and family conflict. Thus, the family strengthening intervention had a positive effect on family communication for those Cohort 1 adults.

For Cohort 2, preliminary findings based on seven sites (22%) suggest that there are statistically significant positive findings for the family communication variables. Steps are being taken to retrieve data from the remaining 11 sites. Cohort 3 has a much more rigorous program evaluation design that includes control/comparison groups and three data collection points pre and post-program exit. Baseline data for Cohort 3 are expected in 9/04.

2.16 Program Title: Best Practices: Centers for the Application of Prevention Technologies (CAPTs)

Performance Goals Strategic Goal: Effectiveness	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of CAPT services provided at the local, county, regional, state, national, or multi-national level to build state-level prevention capacity. (E)	FY 05: TBR 11/04 FY 04: TBR 11/03 FY 03: Additional data being collected to set target FY 02: Baseline	FY 05: TBR 11/05 FY 04: TBR 11/04 FY 03: TBR 11/03 FY 02: Baseline: 17,815	**HHS SP -1**
2. Increase number of systemic change outcomes in prevention systems at the local, county, regional, state, national, or multi-national level. (O) (Replaces Measure 3 from FY 2003 GPRA plan)	FY 05: TBR 11/04 FY 04: TBR11/03 FY 03: Additional data being collected to set target FY 02: Baseline	FY 05: TBR 11/05 FY 04: TBR 11/04 FY 03: TBR 11/03 FY 02: Baseline: 79	
Total Funding:	**2005: $7,300,000** **2004: $7,,100,000** **2003: $8,900,000** **2002: $8,656,000** **2001: $9,000,000** **2000: $6,449,000** **1999: $6,449,000** **1998: $6,410,000** **1997: $5,200,000**		

* Totals include data from States that have not yet been identified in the database.

Program Description and Context

The goal of the CAPTS is to help community, state, and local practitioners to accelerate the conversion of scientific knowledge into effective prevention actions. CAPTs serve State Incentive Grantees and their local sub-recipients, States without the SIG program, many Tribes and US Territories, all 46 US Department of Education Grants to reduce alcohol abuse grantees, and thousands of community-based organizations and coalitions. This program promotes implementation and evaluation of state of the art prevention technologies through the establishment of six regional technical assistance centers.

Since 1997, the CAPTs have been rapidly transferring knowledge about effective science-based substance abuse prevention strategies through three core knowledge application strategies that include: 1) Establishment of a technical assistance network using local experts for each region, 2) Development of training activities, and 3) Innovative use of communication media (e.g., teleconferencing, online events, video conferencing, and World Wide Web-based Decision Support with database transfer capabilities.)

The CAPT data collection system has undergone revisions necessitating revisions for the FY 2003 GPRA measures. The new CAPT data collection system was effective in FY2002. Accordingly, new data from the old system is not available for reporting purposes. Baseline data for the proposed revised measures has been reported using the new system.

The new national CAPT data collection system reflects a number of critical decisions about the most accurate and effective way to assess the work of the CAPTs. For example, the Technical Assistance (TA) database now focuses on overall TA services provided, and includes selected client ratings (satisfaction with and utility of CAPT service provided). The Event database now allows an examination of participant ratings (satisfaction with event and likelihood of using the information received). In future reports, these client satisfaction data will be provided. The new Systemic Outcomes database captures information on substantive changes that are in some way related to the work of the CAPTs. This redesigned data system represents a significant commitment to tracking the impact of CAPT work.

Performance Analysis

Measure 1: Increase the number of CAPT services provided at the local, county, regional, state, national, or multi-national level to build state-level prevention capacity.

This key outcome measure has been revised to reflect the new reporting system which counts number of people served. FY 02 baseline number of people served is 17,815

Measure 2: Increase number of systemic change outcomes in prevention systems at the local, county, regional, state, national, or multi-national level. This measures reflects the new systemic outcomes database, which captures information on substantive changes that are related to the work of the CAPTS FY 02 baseline is 79.

2.17 Program Title: Best Practices: Community-Initiated Prevention Intervention Studies

Performance Goals Strategic Goal: Effectiveness	*Target*	*Actual Performance*	*Refer-ence*
1) Decrease substance abuse among program participants (O)	FY04: Prg. Over FY 03: 10% decrease among 2nd and 3rd phase participants FY 02: 10% decrease among 1st phase participants	FY04: Prg. Over FY 03: 2nd and 3rd phases TBR 9/03 FY 02: Phase I final data: Intervention group: baseline 42%, exit 42% Comparison group: baseline 38%, exit 36%. Changes were not statistically significant. FY 02: Phase 2 and 3 baseline:	**HHS SP -1**

	Establish baseline (2nd and 3rd phase) FY 01: 10% decrease of 1st phase participants FY 00: Establish 1st phase baseline	Intervention group: 18% Comparison group: 24% FY 01:1st phase preliminary baseline data: Intervention group: baseline 9%,exit 5%; Comparison group: baseline 16%; exit 12%. Changes were not statistically significant.	
2) Increase negative attitude toward substance abuse among program participants (youth 12-17 only) (E)	FY04: N/A Program Over FY 03: 2nd and 3rd phases TBR 9/03 FY 02: 10% increase in 1st phase Establish 2nd and 3rd phase baseline FY 01: 10% increase in 1st phase	FY04: N/A Program Over FY 03: 2nd and 3rd phases TBR 9/03 FY 02: 1st phase final data (baseline revised): a)Very wrong to drink beer, wine, etc: Intervention group: Baseline 68%, Exit 73% Comparison group: Baseline 70%, Exit 73 % b) Very wrong to smoke marijuana: Intervention group: Baseline 73%, Exit 79% (Results statistically significant) Comparison group: Baseline 77%, Exit 82% Phase 2 and 3 preliminary baseline: a)Very wrong to drink beer, wine, etc: Intervention group: Baseline 48% Comparison group: Baseline 38% b) Very wrong to smoke marijuana: Intervention group: Baseline 50%, Comparison group: Baseline 38%, FY 01: 1st phase preliminary baseline data compiled 11/01 a) Wrong to drink beer, wine, etc.: Intervention group: baseline 53%, exit 81%; Comparison group: baseline 61%, exit 68% Changes for intervention group were sig. at p<.05 b) Wrong to smoke marijuana Intervention group: baseline 61%, exit 84%; Comparison group: baseline 71%; exit, 81% Changes for both intervention and comparison group were significant at p<.05	

Total Funding:	**2005: 0** **2004: 0** **2003: $14,229,000** **2002: $17,580,000** **2001: $7,580,000** **2000: $ 420,000** **1999: $7,352,000**		

Program Description and Context

The goal of this program is to evaluate effective substance abuse prevention interventions and associated social, emotional, behavioral, cognitive, and physical problems among at-risk populations in their local communities. Grants were made for projects to:1) test science-based interventions in community settings and/or with diverse populations, 2) replicate proven interventions in other populations and/or communities, or 3) continue effective interventions through normal developmental stages.

The first phase of 21 grants was funded in FY 2000. Two additional phases of grants, totaling 25 grants, including 5 for targeting Fetal Alcohol Syndrome (FAS), were awarded at the end of FY 2001. It is expected that funding for phases 2 and 3 will be terminated in FY 2003.

Performance Analysis

Measure 1: Decrease substance abuse among program participants - (For youth ages 12-17, illegal substances included alcohol, tobacco, inhalants, marijuana, and all illegal drugs.)

Phase I: There was no statistically significant change in substance use for youth in either the group that received services (intervention group) or the comparison group, meaning that for phase 1 participants, participation in the program had no effect on substance use. The percentage of youth ages 12-17 reporting any substance use in the past 30 days in the intervention group (n=466) was 42 percent at baseline and exit. The percentage of youth ages 12-17 in the comparison group (n=371) reporting any substance use was 38 percent at baseline and 36 percent at exit.

Measure 2: Increase negative attitude toward substance abuse among program participants (youth 12-17 only)

Phase I: Although the program missed its target of a 10% increase in negative attitude for youth ages 12-17, it did achieve a statistically significant 5% increase in negative attitude toward marijuana among the intervention group. Negative attitude toward alcohol increased 1% in the intervention group, while it decreased for the comparison group.

Phase II and III: The percentage of youths ages 12-17 that found alcohol use to be very wrong at baseline was 48% in the intervention group (n=644) and 38% in the comparison group (n=584).

The percentage of youths ages 12-17 that found marijuana use to be very wrong at baseline was 50% in the intervention group (n=570) and 38% in the comparison group (n=517).

HIV/AIDS Priority Area

2.18 Program Title: Targeted Capacity Expansion: Substance Abuse Prevention and HIV Prevention in Minority Communities

Performance Goals Strategic Goal: Capacity	*Targets*	*Actual Performance*	*Refer-ence*
1.Increase perception of risk for substance use/abuse for youth receiving services which integrate substance abuse prevention and HIV prevention. (O)	FY 05: TBR 9/03 FY 04: 15% increase FY 03: Establish Cohort 2 baseline FY 02: 50% increase FY 01: 30% increase FY 00: Establish baseline	FY 05: TBR 9/05 FY 04: TBR 9/04 FY 03: TBR 9/03 FY 02: Final Cohort 1data - TBR 9/03 FY 01: 20% increase FY 00: Baseline: 30% of all youth in study believe smoking marijuana once or twice a week is of great physical risk	**HHS SP –1 HP 1 26-10 26-11d, 26-14, 26-15**
2. Increase age of first sexual encounter for youth receiving services which integrate substance abuse prevention and HIV prevention. (O)	FY 03: Measure dropped FY 02: 15% of youth delay FY 01: 10% of youth delay FY 00: Baseline set	FY 03: Measure dropped FY 02: TBR 9/03 FY 01 The median age of sexually inactive youth clients at baseline was 14.71. At Post-Test, the median age was 15.67. (6.1% increase) FY 00: Baseline: Of all sexually active youth at baseline, 95% initiated activity at age 16 or less. Of sexually inactive youth the median age at baseline was 17.71years	**HP 2 - 26-10, 26-17, 26-16**
3. Increase the number of service Programs that integrate substance abuse prevention and HIV prevention services to: (O, E)	FY 05: TBR 9/04 FY 04: TBR 9/03 FY 03: TBR 9/03 FY 02: 55 services FY 01: Increase services by 30% FY 00: Establish baseline	FY 05: TBR 9/05 FY 04: TBR 9/04 FY 03: TBR 9/03 FY 02: Final Cohort 1 data TBR 9/03 FY 01: Cohort 1- (a) youth: 100% increase (b) women: 100% increase (c) women and their children: 100% increase FY 00: Cohort 1-Baseline.: (a) youth: 1 (b) women: 0 (c) women and their children: 0	

Total Funding	**2005: $38,100,000** **2004: $38,300,000** **2003: $38,900,000** **2002: $38,100,000**		

Program Description and Context

The goal of this program is to increase the capacity of communities serving the target populations to deliver evidence-based substance abuse prevention and HIV prevention services. Prior to this initiative, few programs integrated prevention services in the fields of substance abuse and HIV. Substance abuse prevention and HIV prevention healthcare services need to be delivered in a comprehensive system to address the dual epidemics of substance abuse and HIV. Outcomes are anticipated to include decreasing the number of substance abuse-related HIV infections while decreasing the consequences of substance abuse. Increased service capacity will help address the health emergency within the communities targeted by the National Minority AIDS Initiative.

This multi-disciplinary approach disseminates integrated prevention models to meet the needs of racial/ethnic communities. The most critical challenge is the promotion of education of public health providers in substance abuse and HIV/AIDS to increase integrated prevention intervention strategies to address multiple risks, reducing known risk factors that cross domains.

FY 2001 funding was designed to expand the capacity of community-based organizations that serve predominantly racial and ethnic minority populations that are disproportionately impacted by substance abuse and the HIV/AIDS epidemic. 77 grantees were funded. There are three initiatives within the FY 2001 program: 1) One-year funding for "planning" cooperative agreements for the establishment of new prevention initiatives; 2) Three-year funding for "adult-focused" cooperative agreements to improve and expand the implementation of an existing system of services to include primary health care, substance abuse and HIV prevention models to minority adults; and 3) Three-year funding for "youth-focused" cooperative agreements to implement substance abuse and HIV prevention services targeting minority youth.

In FY 2002 another cohort of project grantees was funded (Cohort 3): 48 three year service grants to provide prevention interventions and 46 one-year planning grants to improve infrastructure. A Program Evaluation Center (PEC) was also funded in FY 2002 to support this cross-site evaluation effort for project grants funded under this program initiative in FY 2001. The PEC is funded as a performance-based contract. A modification to the PEC contract is currently in progress to support evaluation efforts for cohort 3.

A new cohort of grants for this program is planned for FY 2004.

Performance Analysis

Measure 1: Increase perception of risk for substance use/abuse for youth receiving services which integrate substance abuse prevention and HIV prevention.

Baseline data were collected in FY 2001. The target was not reached, however, there was a positive result. Final cohort 1 data will be available 9/03.

Measure 2: Increase age of first sexual encounter for youth receiving services which integrate substance abuse prevention and HIV prevention.

This measure will be dropped in FY 2003 to reduce the number of measures. Baseline data were collected in FY 2001. Collection of baseline data was delayed because of stringent requirements for IRB clearance, certificates of confidentiality, and single project assurance. Such precautions are essential given the sensitive nature of this project, and will ultimately result in better data. Data will be reported in September 2003.

Measure 3: Increase the number of service Programs that integrate substance abuse prevention and HIV prevention services

The FY 2001 target was exceeded. The total increase in services was 47 services. The number of services for each target group was as follows: (a) youth: 13; (b) women: 8; and (c) women and their children: 26. Because of the high percentage increase compared to the baseline (47 services in FY 01 compared to 1 service in FY 00, the FY 02 target has been changed upward and converted to a number of services rather than a percent increase. For cohort 2, baseline data will be reported in September 2003. At that time, the numerical target will be set at 30% above the baseline. To account for the different target populations of the various cohorts, the three different types of integrated services have been aggregated into a single measure.

Programs with Separate Budget Lines

Prevention and Early Intervention Priority Area

2.19 Program Title: Synar Amendment Implementation Activities (Section 1926)

Performance Goals Strategic Goal: Accountability	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase number of States whose retail sales violations is at or below 20% (O, E)	FY 05: 50 States+DC and PR FY 04: 50 States FY 03: 50 States, FY 02: 35 States FY 01: 26 States (Was 36 states) FY 00: 26 States	FY 05: TBR 7/05 FY 04: TBR 7/04 FY 03: TBR 7/03 FY 02: 42 States FY 01: 30 States FY 00: 25 States FY 99: 21 States FY 98: 12 States FY 97 Baseline: 4 States	**HHS SP -1**

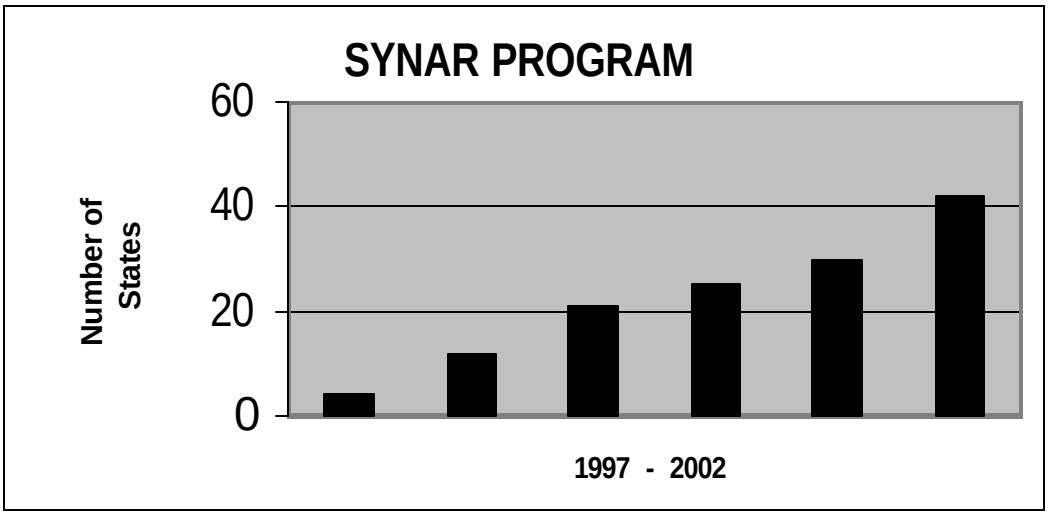
Total Funding:	**2005: $650,000** **2004: $650,000** **2003: $632,300**		

Program Description and Context

The goal of this program is to reduce the sales rate of tobacco products to minors in all States. This program provides assistance to the States to enhance their ability to comply with Synar regulations. All States have established data collection and enforcement procedures to comply with Synar regulations, and many States are receiving technical assistance to improve their established procedures. CSAP also supports the States in reducing retail sales of tobacco to youth by providing guidance on policy and in assisting States with the identification of tobacco retail outlet lists. In addition, CSAP also provides guidance to improve collaboration between State and local authorities responsible for Synar compliance.

Performance Analysis

Measure 1: Increase number of States whose retail sales violations is at or below 20%
In FY 03, the target was not fully met. This is the outcome measure. In FY 2002 and FY 2001, the target was exceeded. States continue to be required to achieve a 20% target rate beyond FY 2003. States that fail to meet their target rates may receive a penalty of a 40% reduction in their total Block Grant funds. U.S. Territories continue to experience difficulty in meeting the required 20% Synar goal. According to SAMHSA's reauthorization language (Title XIX, Subpart II, section 1932(c)), the Secretary of Health and Human Services has authority (delegated to the SAMHSA Administrator) for granting a waiver. A waiver was approved for all of the US territories with the exception of Puerto Rico. For FY 2004, the territories will have the option to request a waiver as an alternative to the 20% goal requirement. Future targets will be set with that waiver in mind.



2.20 Program Title: 20% Prevention Set-aside, Substance Abuse Prevention and Treatment (SAPT) Block Grant

Performance Goals Strategic Goal: Capacity	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase satisfaction with technical assistance. (O)	FY 05: Maintain at 90% FY 04: Maintain at 90% FY 03: Maintain at 90% FY 02: Maintain at 90% with 80% response rate and 50% "outstanding" FY 01: 90% with 80% response rate; increase "outstanding" rating to 40% FY 00: 90% with 60% response rate	FY 05: TBR 11/06 FY 04: TBR 11/05 FY 03: TBR 11/04 FY 03: TBR 11/03 FY 02: 90% with 50% response rate FY 01: revised satisfaction survey under development FY 00: 90% with 60% response rate FY 99: 94% satisfaction with 100% response rate FY 97 Baseline: 90% satisfactory rating, with 60% responding; 25% outstanding rating	**HHS SP -1**
2. Increase the number of States using Minimum Data Set (MDS) process measures) (O,E)	FY 03: Measure dropped FY 02: 30 States use MDS process measures FY 01: 21 States use MDS process measures FY 00: 5 outcome measures tested in 11 States (Note: Data on outcome measures are now reported under measure 6)	FY 03: Measure dropped FY 02: TBR 10/03 FY 01:27 States FY 00: 26 States FY 99: 20 States FY 97: Baseline: 11 States	
Total Funding:	**2005: $357,000,000** **2004: $357,000,000** **2003: $357,000,000** **2002: $331,000,000** **2001: $309,890,000** **2000: $304,850,000** **1999: $301,150,000** **1998: $248,920,000** **1997: $248,920,000**		

Program Description and Context

As required by legislation, 20 percent of Block Grant funds allocated to States must be spent on substance abuse primary prevention services. CSAP administers the primary prevention components of the SAPT Block Grant Prevention service funding varies significantly from State to State. Some States rely solely on the set-aside to fund their entire prevention system; others use the funds to target gaps and enhance existing program efforts. CSAP requires under regulation that the States use their Block Grant funds to support a range of prevention services and activities in six key areas to ensure that each State offers a comprehensive system for preventing substance abuse. The six areas are information dissemination, community-based process, environmental strategies, alternative activities, education, and problem identification and referral. SAPT Block Grant funds are the foundation of most States' prevention systems, driving their prevention planning processes and setting standards for their overall prevention systems.

Development of performance measures continues to be an area of highest priority for CSAP. Performance information is used throughout the Center. Accomplishments have placed the agency in a strategic position to implement key provisions of the Public Law 106-310, the Children's Health Act of 2000. This law requires CSAP to develop a plan for creating flexibility and accountability for States based on a common set of performance measures.

Performance Analysis

SAMHSA is working toward transforming the Block Grant into Performance Partnership Grants (PPGs). The PPGs will require greater accountability in exchange for State flexibility to design, implement, and evaluate community-based substance abuse prevention programs. The PPGs include the development of performance measures to support planning in the Block Grant. At present, SAMHSA is working with the States to identify core measures.

Measure 1: Increase satisfaction with technical assistance

The goal of 90% satisfaction was met. A revised customer satisfaction survey received OMB clearance in December 2001 and has been phased in, resulting in lower than expected response rates. The new survey instrument will permit long-term (12 month) follow-up, and will assist us in obtaining 100% feedback.

Measure 2: Increase the number of States using Minimum Data Set

The FY 2001 target was exceeded. Final reporting on this measure will occur in FY 2003. At that point, this measure will be dropped. As background, MDS originated as a disk-based system, and has since become a web/server-based system. The disk-based system is becoming obsolete, and States are required to use servers to operate the system. While some States have proceeded with implementation of server-based systems, others have not had the resources to do so. CSAP has attempted to mitigate these difficulties by offering server space on its own contractor's server to any State free of charge for one year. With the gradual transition to the Performance Partnership Grant approach, more States are expected to implement data collection systems collecting data on these measures.

Simultaneously, CSAP is proceeding with the development of a web-based State Management Information System (SMIS) as part of its Decision Support System Website. The State Management Information System will subsume all the functions of the disk-based MDS.

Substance Abuse Treatment

The mission of the Center for Substance Abuse Treatment (CSAT) is to improve the health of the Nation by bringing effective alcohol and drug treatment to every community. CSAT's primary objectives are to increase alcohol and drug treatment throughout the United States, and to promote effective treatment through the adoption of evidence-based practices.

Substance use disorders, including drug and alcohol abuse and addiction, and misuse of prescription drugs and over-the-counter medications affect the young and elderly, rich and poor, and people of every racial and ethnic group. The effects are seen in permanent damage to our children, the transmission of HIV/AIDS and other communicable diseases, criminal involvement, premature and preventable deaths, and economic and social consequences estimated to cost the nation more than $294 billion each year (*National Estimates of Expenditures for Substance Abuse Treatment, 1997*, CSAT, February 2001).

The FY 2005 budget proposal continues to support the President's Drug Treatment Initiative emphasizing an increase to maintain the SAPT Block Grant at the current service level. At the 4% increase level, the FY 2004 "Access to Recovery" program would receive an increase to support data infrastructure for this major new program. For 2004 and 2005, many measures have been dropped to focus on key measures and to comply with HHS guidelines to reduce the number of measures. In alignment with the President's Management Agenda to expand electronic government, CSAT has implemented an automated data entry and reporting system. All grantees are now reporting GPRA data electronically to CSAT.

Targeted Capacity Expansion

CSAT has made considerable effort to move in the direction of coordinating performance and budget data by the introduction of an automated GPRA data collection and reporting system across all of its discretionary programs. With the introduction of the current GPRA data entry and reporting system, all data are now collected and reported near real time by summary to date as well as by fiscal years. Given the implementation of this new system, all of the Targeted Capacity Expansion (TCE) services program tables included in this report have been revised. The apparent discontinuity in the FY03 and later targets for TCE is the result of a shift in FY04 to using revised targets that are consistent with our long-term PART goals.

For FY05 CSAT has set four standard performance measures for the TCE program budget line: two performance measures for the services activities and two performance measures for the knowledge application activities. For this HHS submission CSAT has included a performance

table and narrative for each of the individual TCE programs funded from the TCE program budget line. CSAT is in the process of aggregating the reporting for these programs so that in the OMB submission there will be one narrative and four measures tracking performance for the entire TCE program budget line. This will reduce the number of TCE measures from 21 to 6. We expect also each year to select programs of special interest for additional descriptive reporting. For example, in FY04, as data become available, we expect to include additional descriptive reporting on the new FY 2003 Screening and Brief Intervention, Referral and Treatment (SBIRT) and later, on the new FY 2004 Access to Recovery program. This is developmental and will be completed in the summer for the fall submission.

Proposed Long-Term CSAT PRNS Program Measures

The 2002 OMB PART review of CSAT PRNS programs identified the need to develop long-term goals. These goals relate to the SAMHSA agency level goals for accountability, capacity and effectiveness. The goals are listed in the table below:

Capacity
Services Projects long-term goals: By 2006, increase the number of clients served to 51,054. (O)
Best Practices long-term goals: By 2006, increase the number of events to 650. (O)
Best Practices long-term goals for Knowledge Application Program (KAP): By 2006, increase the number of publications to 194.
Efficiency
Services Projects (TCEs) **Efficiency Long-Term Goal:** By 2006, increase by 16% the percentage of grantees whose per person costs fall within an acceptable range. (E)
Effectiveness
Services Projects Long-Term Goal: By 2006, increase by 8% the number of people who show no past month substance use 6 months post treatment admission. (O)
Best Practices Long-Term Goal: By FY 2006, increase by 8% the percentage of participants who have used information from a best practices activity to change their practice. (O)

Programs included in this report are:

2.21 TCE: General Populations
2.22 TCE: Strengthening Treatment Access and Retention
2.23 TCE: Community Action Grants
2.24 TCE: Strengthening Communities-Youth
2.25 Best Practices: Addiction Technology Transfer Centers (ATTCs)
2.26 Best Practices: Knowledge Application Program
2.27 TCE: Addictions Treatment for Homeless
2.28 TCE: HIV

2.29 Program Title: TCE: Community-Based Substance Abuse and HIV/AIDS Outreach Program
2.30 Screening and Brief Intervention, Referral and Treatment
2.31 SAPT Block Grant
2.32 Opioid Agonist Medical Maintenance
2.33 Access to Recovery

Treatment Capacity Priority Area

2.21 Program Title: TCE: General Populations

Performance Goals Strategic Goal: Capacity	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of clients served. (O, E)	FY 05: 8268 FY 04: 8106 FY 03: Maintain at 21,000** FY 02: Maintain at 21,000	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 7,792 clients	**HHS SP -1**
2. Increase the percentage of adults receiving services who (e) had no past month substance use* (O, E)	FY 05: 68.8% FY 04: 66.8% FY 03: Maintain at 35%** FY 02: 35%	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 62.8%	**HP 2 26-10c**
Total Fundi ng:	**2005: $27,875,000** **2004: $42,389,000** **2003: $50,774,000** **2002: $53,858,889**		

*Measures 2a-2d dropped from future reporting per discussion with OMB.
** The apparent discontinuity in the FY03 and later targets is the result of a shift in FY04 to using revised targets that are consistent with our long-term PART goals.

Program Description and Context

The General Populations program, created in 1998, is designed to enhance or expand a community's ability to provide a comprehensive, integrated, creative, and community-based response to a targeted, well documented substance abuse treatment capacity problem. The program addresses gaps in treatment capacity by supporting rapid and strategic responses to demands for substance abuse treatment services (including both alcohol and drugs) in communities with serious, emerging drug problems. The program also builds quality improvements into the treatment system, supporting SAMHSA's Effectiveness goal as well as the Capacity goal. Grantees include State, regional, and local government entities.

CSAT recognizes the disparity between the needs of certain under-served and under-represented minority populations and the ability to provide them treatment services. Within this program, cluster groups of current TCE grantees have been formed to deal with the specific issues/ needs of particular populations (e.g., American Indian/Alaskan Natives; criminal justice) and particular drug trends (e.g., methamphetamine.) The program cluster groups have been successful in reaching out to these populations. A case in point is the new grants awarded in the

Native American cluster. American Indians and Alaska Natives are more severely affected by substance abuse than any other racial/ethnic group in the United States. In addition, the Congressional Black Caucus earmarked several million dollars for HIV/AIDS to the African American and other minority communities including adolescents as well as women and their children. Although the HIV/AIDS funding has been incorporated into the Targeted Capacity Expansion Program budget line, the two programs have been broken out for the purpose of GPRA reporting.

The available data indicates that there is generally some lag between funding award, program start-up (including enrollment of clients and initiation of data collection), and data reporting with considerable variability among programs. As the program matures, the proportion of programs reporting annual data generally increases.

As discussed in the introduction, we will be aggregating our performance for the TCE services activities programs in the next GPRA submission. For the services activities the two measures are: persons served and an effectiveness measure.

Performance Analysis

Measure 1: The number of clients served represents fiscal year data.

CSAT's primary mission is to bring effective alcohol and drug treatment to every community. The number of people served reflects the extent to which CSAT funding has supported the provision of service. This is measured through the GPRA Core Client Outcome Tool. There is linkage between the budget and performance measurement. Appropriations are requested in order to reach specified performance targets.

The previously set target was missed for FY02. One contributing factor for this result is the fact that funding allocation for new grants was reduced. In addition, increased program oversight via the GPRA Web-based reporting system was not fully operational until January FY03 and the validity of previous estimates was unknown. CSAT will continue to implement its corrective management plan to significantly strengthen and improve grantee oversight, data submission, and performance.

Measure 2: Indicator "(e) had no past month substance use" is a key outcome indicator and will be reported as a 6-month percentage.

The target was met for FY02. The percentage of adults receiving services who had not used substances in the past month at 6 months post admission, reflects the extent to which CSAT funding has supported the provision of effective service. This is measured through the Core GPRA Client Outcome Tool. There is a relationship between performance and budgetary requests. Appropriation requests are based on the performance targets that are set to further implement performance based budgeting.

2.22 Program Title: TCE: Strengthening Treatment Access and Retention (STAR) (Formerly Practice Improvement Collaborative and Formerly Practice Research Collaborative)*

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase stakeholder knowledge application events or activities. (O)	FY 05: 40 FY 04: 35 FY 03: 30 FY 02: 25	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 7	**HHS SP -1**
2. Increase the percentage of stakeholders who have used information from KA events or activities to promote or effect change. (O)	FY 05: Maintain at 89% FY 04: Maintain at 89% FY 03: Maintain at 89% FY 02: 25%	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 89.6%	
Total Funding:	**2005: $5,100,000** **2004: $5,212,200** **2003: $5,100,000** **2002: $5,275,104** **2001: $5,275,104**		

Program Description and Context

The Strengthening Treatment Access and Retention (STAR) program enhances the quality of substance abuse treatment through the use of demonstrated quality improvement methods to implement effective access and retention practices. The STAR program replaces the Practice Improvement Collaborative (PIC) and Practice Research Collaborative (PRC) programs.* The PIC and PRC programs supported the adoption of evidence based clinical and services delivery practices, based upon the needs identified by community stakeholders. The PRC program terminated in FY02; the PIC program terminates in FY04. The STAR program builds on the lessons learned from prior programs; (i.e., the crucial role of the organization in supporting and sustaining treatment improvement practices. STAR grantees will be expected to identify access and retention improvements that address targeted program needs, implement effective clinical and administrative practices that address these needs utilizing quality improvement processes and participate in a learning community of grantees. The STAR program will operate in FY03 through FY05.

Program Performance Analysis

For FY05 we have set two performance measures for the TCE program budget line: two performance measures for the services activities and two primary performance measures for the knowledge application activities. For the knowledge application activities the two primary measures consist of: number of events or persons trained and a minimum of one effectiveness measure.

Measure 1: Increase stakeholder knowledge application (KA) events or activities.

CSAT's mission includes promoting effective treatment through the adoption of evidence-based practices. Tracking the number of events (trainings, meetings, and technical assistance activities) is critical in documenting the delivery of service and dissemination of relevant information to the field. This is measured by the Core GPRA KA Customer Satisfaction Tool. There is a relationship between performance and budgetary requests. Appropriation requests are based on the performance targets that are set.

The target of 20 events was not met. Only 7 events were held in FY 2002. Future targets can be met. Program needs at least two measurement points to determine whether a corrective action plan is warranted. Data are still not available and the Government Project Officer is conducting telephone conference calls with grantees to identify possible corrective action measures.

Measure 2: Increase percentage of stakeholders who have used information from KA events or activities to promote or effect change.

CSAT's mission includes promoting effective treatment through the adoption of evidence-based practices. CSAT conducts events (trainings, meetings, and technical assistance activities) where relevant and scientifically based findings are disseminated to the field. A critical outcome is that the information disseminated results in an actual change in service delivery techniques. This is measured through collection of Core GPRA KA Customer Satisfaction Follow Up Tool. It is expected that an increase in budget allocation will result in more dissemination activities and a wider penetration of critical information.

All FY02 targets were substantially exceeded.

2.23 Program Title: TCE: Community Action Grants

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
3. Increase the percentage of stakeholders who have used information from events or activities.* (O)	FY 05: NA – Prg. over FY 04: NA – Prg. over FY 03: 89% FY 02: Establish baseline	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: TBR 8/03	**HHS SP -1**
Total Funding:	**2005: $0** **2004: $0** **2003: $1,533,000** **2002: $3,000,000** **2001: $1,041,466** **2000: $ 672,299**		

*Measures 1-2 dropped from future reporting per discussion with OMB.

Program Description and Context

The CSAT Community Action Grant Program is a science to services program for one year grants intended to encourage the adoption of exemplary substance abuse treatment and prevention practices through partnership, building consensus, and aiding in eliminating barriers, with the ultimate goal of adapting service models to meet local needs. Exemplary practices are defined as those practices that have a reliable record of improving outcomes for those receiving the service.

In September 1998, the Center for Substance Abuse Treatment, in partnership with the Center for Mental Health Services and the Center for Substance Abuse Prevention, funded the first round of Community Action Grants (CAGs) that included a substance abuse focus. Hispanic Initiatives were the first CAGs to assist community groups in adopting exemplary practices for improving delivery of substance abuse treatment services to the Hispanic population. In September 1999, the Center for Substance Abuse Treatment initiated the first round of CSAT Action Grants and funded the second round of Hispanic Priority Action Grants. Performance tables for this program, with its mental health and substance abuse components are found in both CMHS and CSAT GPRA sections.

Program Performance Analysis

Formerly Measure 3, Now Measure #1: Increase percentage of stakeholders who have used information from KA events or activities to promote or effect change.

CSAT's mission includes promoting effective treatment through the adoption of evidence-based practices. A critical program outcome is that the information disseminated results in an actual change in service delivery techniques. This is measured by the core GPRA KA Satisfaction Tool. There is a relationship between performance and budgetary requests. Appropriation requests are based on the performance targets that are set.

The Community Action Grant (CAG) Program grantees were notified of GPRA data requirements upon initiation of the grant. Following OMB approval, the grantees received the surveys in June of 2002 and have begun data collection. Data are not available and the Government Project Officer is conducting telephone conference calls to prompt data reporting.

2.24 Program Title: TCE: Strengthening Communities-Youth

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of clients served. (O, E)	FY 05: 310 FY 04: 300 FY 03: 260 FY 02: NA (Establish baseline)	FY 05: TBR 8/05 FY 04: TBR 08/04 FY 03: TBR 08/03 FY 02: Program Start up	**HHS SP -1**
2. Increase the percentage of youth receiving services who (e) had no past month substance use.* (O)	FY 05: 42% FY04: 40% FY 03: 30% FY 02: NA	FY 05: TBR 8/05 FY 04: TBR 08/04 FY 03: Establish baseline FY 02: NA	

Total Funding:	**2005: $22,875,000** **2004: $19,347,480** **2003: $20,898,000** **2002: $16,931,000** **2001: $ 2,931,000**		

*Measures 2a-2d dropped from future reporting per OMB.

Program Description and Context

CSAT has funded twelve cooperative agreements to assist communities in their efforts to address drug and alcohol problems among youth, for whom there is a lack of a treatment system, infrastructure, and continuum of care. Emphasis will be on providing a continuum of gender specific, culturally appropriate services to youth and their families to include outreach, intervention, referral, assessment, counseling, case management, and aftercare. These services will be facilitated by the development of a Management Information System that will track the youth throughout the continuum of care.

"Community" is defined by the grantee, and may refer to an entire city, a section of a city, an entire Tribal Authority or section of their jurisdiction, a rural area such as a county, or a consortium of agencies in a contiguous geographic area. Grantees will develop linkages and networking mechanisms in communities that will facilitate identification, assessment, referral and treatment of youth with substance abuse problems. The grants will also develop and implement outreach activities to educate the community (youths, parents, teachers, justice personnel, pediatricians and primary care physicians, the faith community, etc.) to enable early identification, referral and treatment.

Program Performance Analysis

Measure 1: The number of clients served represents fiscal year data for youth.

CSAT's primary mission is to bring effective alcohol and drug treatment to every community. The number of youth served reflects the extent to which CSAT funding has supported the provision of service. This is measure through the collection of GPRA Core Client Outcome Tool. The program was initiated in October 2002 and data are not yet available.

Measure 2: Increase the percentage of youth who "(e) had no past month substance use"

The percentage of adults receiving services who had not used substances in the past month at 6 months post admission, is a key outcome indicator and will be reported as a 6-month percentage. This measure reflects the extent to which CSAT funding has supported the provision of effective service. This is measured: through GPRA Core Client Outcome Follow Up Tool. The program was initiated in October 2002 and data are not yet available. There is a relationship between performance and budgetary requests. Appropriation requests are based on the performance targets that are set.

2.25 Program Title: Best Practices: Addiction Technology Transfer Centers (ATTCs)

Performance Goals *Strategic Goal: Effectiveness*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of individuals trained per year. (O,E)	FY 05: 26,520 FY 04: 26,000 FY 03: 25,000 FY 02: 23,500 FY 01: 22,000 FY 97: Estab. baseline	FY 05: TBR 8/05 FY 04: TBR 8/05 FY 03: TBR 8/04 FY 02: TBR 8/03 FY 01: 24,721 FY 98: 6,300	**HHS SP -1**
2. Increase the percentage of stakeholders who have used information from "Best Practice" events or activities to promote or effect change. (O)	FY 05: 92% FY 04: 90% FY 03: 80%** FY 02: 70% FY 97: Estab. Baseline	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 86.3%	
Total Funding:	**2005: $8,192,000** **2004: $4,599,000** **2003: $7,724,000** **2002: $4,500,000**		

** The apparent discontinuity in the FY03 and later targets is the result of a shift in FY04 to using revised targets that are consistent with our long-term PART goals.

Program Description and Context

Addiction Technology Transfer Centers (ATTCs) were created to promote the adoption of best practices to improve the effectiveness of substance abuse treatment. One key component in transferring addiction related technology is to provide evidence-based education and training to substance abuse treatment professionals.

The ATTC Network produces addiction-related publications to keep treatment professionals updated on the latest research and other cutting-edge issues that impact their work. The Network also provides ongoing education opportunities for the substance abuse field. Some of the innovative technologies utilized to provide education and training include: symposia, institutes, exhibit booths, newsletters, Web sites, meetings and technical assistance. Customers include a variety of professionals in fields such as addiction treatment, public health, and mental health, community corrections, social work, and criminal justice. These professionals connect with the ATTC individually or via Single State Authorities, academic institutions, community-based and managed care organizations, professional associations, and community organizations.

The ATTC now covers 50 States, Puerto Rico, the Virgin Islands, the District of Columbia, and the Pacific Trust Territories, and includes a National Coordinating Center Office.

Program Performance Analysis

Measure 1: Increase the number of individuals trained per year.

The target for FY01 was exceeded; data for FY02 will be reported 8/03. This is a key measure tracking CSAT's mission of promoting effective treatment through the adoption of evidence-

based practices. Tracking the number of training events is critical in documenting the delivery of service and dissemination of relevant information to the field. This is measured through the Core GPRA KA Customer Satisfaction Training Tool. There is a relationship between performance and budgetary requests. Appropriation requests are based on the performance targets that are set.

These trained individuals, ranging in status from recent graduates to administrators, are now more effective in meeting the needs of a diverse client population.

Measure 2: Increase percentage of stakeholders who have used information from "Best Practice" events or activities to promote or effect change.

The FY02 target was substantially exceeded. CSAT's mission includes promoting effective treatment through the adoption of evidence-based practices. CSAT conducts trainings where relevant and scientifically based findings are disseminated to the field. A critical outcome is that the information disseminated results in an actual change in service delivery techniques. This is measured through the Core GPRA KA Customer Satisfaction Training Follow Up Tool. It is expected that an increase in budget allocation will result in more dissemination activities and a wider penetration of critical information.

2.26 Program Title: Best Practices: Knowledge Application

Performance Goals *Strategic Goal: Effectiveness*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of targeted, products produced: (O,E) Other primary and companion products (e.g.: New resource documents, Quick Guides, KAP Keys, Substance Abuse in Brief, other periodicals)	FY 03: Measure dropped FY 02: 35 FY 01: 25	FY 03: Measure dropped FY 02: TBR 8/03* FY 01: 69 products	**HHS SP -1**
2. Increase the percentage of: (O) (a) Satisfaction with products	FY 05: 77% FY 04: 75% FY 03: 70% FY 02: 65%	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: TBR 10/03*	
(b) Recipients of products who shared product information with a colleague;	FY 05: 32% FY 04: 30% FY 03: 25% FY 02: 20%	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: TBR 10/03*	
(c) Recipients of products who used information contained in products to promote or effect change.	FY 05: 66% FY 04: 65 % FY 03: 60% FY 02: 55%	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: TBR 10/03 FY 02: TBR 10/03*	

Total Funding:	**2005: $4,500,000** **2004: $4,803,400** **2003: $4,000,000** **2002: $3,800,000** **2001: $3,700,000** **2000: $3,600,000**		

*Data has not been entered into data reporting system - see performance narrative below.

Program Description and Context

The purpose of the Knowledge Application Project (KAP) is to produce print and non-print products (e.g., videos and audiotapes) that contain information about effective substance abuse treatment practices. The information is then disseminated to professionals working in treatment programs and others working in related professions, such as primary care physicians and criminal justice personnel. KAP staff also conduct workshops that focus on helping treatment professionals implement more effective treatment practices.

KAP products include the following: (1) CSAT's Treatment Improvement Protocols (TIPs) series, which provide guidance on specific issues that need to be addressed in providing effective treatment (e.g., treatment for substance-abusing individuals who have HIV/AIDS); (2) companion or ancillary products that provide summary information for a particular audience (e.g., booklets for counselors on how to address the emotional issues that a person with HIV/AIDS may experience); (3) treatment manuals and client workbooks (e.g., a therapist's manual and client workbook that address anger management); (4) the CSAT Advisory, which provides information to treatment providers on a rapidly emerging problems (e.g., an advisory on OxyContin abuse); (5) CSATx Data, an electronic periodical designed to help providers understand how research findings apply to treatment practices; and (6) Substance Abuse in Brief, a periodical for professionals who do not work in substance abuse treatment but are interested in the issue. All these products are written and formatted in ways that help readers to identify the information they need quickly and easily; products also include strategies to help readers implement approaches that will improve treatment effectiveness.

Program Performance Analysis

This program is funded under a contract. The performance is mandated by a contract. Therefore, baseline have been set using contract terms.

Measure 1: The target for FY01 has been met. The measure was deleted for 2002 to comply with reductions in measures mandated by HHS.

Measure 2: Increase the percentage of: (a) Satisfaction with products (b) Recipients of products who shared product information with a colleague; (c) Recipients of products who used information contained in products to promote or effect change.

CSAT's mission includes promoting effective treatment through the adoption of evidence-based practices. Tracking the number of events (trainings, meetings, and technical assistance

activities) is critical in documenting the delivery of service and dissemination of relevant information to the field. This is measured through the Core GPRA KA Customer Satisfaction Follow Up Tool. There is a relationship between performance and budgetary requests. Appropriation requests are based on the performance targets that are set.

No data is available to date, but baselines will reported on 10/03

Homeless Priority Area

2.27 Program Title: TCE: Addictions Treatment for Homeless

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of clients served (O,E)	FY 05: 1566 FY 04: 1533 FY 03: 900* FY 02: Estab.baseline	FY 05: TBR 8/05 FY 04: TBR 08/04 FY 03: TBR 08/03 FY 02: 1,473	**HHS SP -1**
2. Increase the percentage of adults receiving services who: (e) had no past month substance use. (O)	FY 05: 77.1% FY 04: 75.1% FY 03: 20%** FY 02: Estab.baseline	FY 05: TBR 8/05 FY 04: TBR 08/04 FY 03: TBR 08/03 FY 02: 71.1%	
Total Funding:	**2005: $28,839,000** **2004: $29,433,600** **2003: $26,835,000**		

** The apparent discontinuity in the FY03 and later targets is the result of a shift in FY04 to using revised targets that are consistent with our long-term PART goals.

Program Description and Context

This program is designed to link substance abuse services with housing programs and other services for homeless persons, and to secure and maintain housing for homeless persons with substance abuse or co-occurring substance abuse and mental disorders. The program supports 17 cooperative agreements. Each project, incorporating its own intervention, is embedded within an integrated, comprehensive, community-based system of care.

Program Performance Analysis

Measure 1: Increase the number of clients served.

The baseline was set for FY02 and a 2 % increase was set in alignment with PART for the subsequent targets. CSAT's primary mission is to bring effective alcohol and drug treatment to every community. The number of people served reflects the extent to which CSAT funding has supported the provision of service. This is measured through the Core GPRA Client Outcome Tool.

Measure 2: Increase the percentage of adults receiving services who: (e) had no past month substance use.

The baseline was set for FY02 and a 2 % increase was set in alignment with PART for the subsequent targets. The percentage of adults receiving services who had not used substances in the past month at 6 months post admission, reflects the extent to which CSAT funding has supported the provision of effective service. This is measured by the Core GPRA Client Outcome Tool. There is a relationship between performance and budgetary requests. Appropriation requests are based on the performance targets that are set.

HIV/AIDS and Hepatitis C Priority Area

2.28 Program Title: TCE: Targeted Capacity Expansion-HIV

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of clients served. (O, E)	FY 05: 6260 FY 04: 6140 FY 03: 12,000 FY 02: 17,215	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 5,902	**HHS SP -1**
2. Increase the percentage of adults receiving services who: (e) had no past month substance use. (O)	FY 05: 64.7% FY 04: 62.7% FY 03: 45% FY 02: 43%	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 58.7%	
3. To reduce risky behaviors associated with contracting HIV and other infectious diseases: (O)			
(a) Sexual risk behaviors	FY 05: 47% FY 04: 45% FY 03: 42% FY 02: 40% FY 01: 37.7%	FY05: TBR 8/06 FY 04: TBR 8/05 FY 03: TBR 8/04 FY 02: TBR 8/03 FY 01: 40.7%	
(b) Other risk factors	FY 05: 22% FY 04: 20% FY 03: 18% FY 02: 15% FY 01: 12%	FY05: TBR 8/05 FY 04: TBR 8/05 FY 03: TBR 8/04 FY 02: TBR 8/03 FY 01: 14%	
Total Funding:	**2005: $60,695,000** **2004: $58,649,514** **2003: $61,191,000** **2002: $57,362,000** **2001: $44,698,800**		

Program Description and Context

This TCE program specifically targets for treatment African American, Latino/Hispanic and other racial and ethnic minority populations that have been disproportionately impacted by the twin epidemics of substance abuse and HIV/AIDS. The program was designed as an ongoing program of three-year grants to address critical gaps in substance abuse treatment capacity. Specifically, grants address the availability and accessibility of the best substance abuse treatment and HIV/AIDS services.

The program also addresses substance abuse, and associated treatment needs for sexually transmitted diseases (STDs), TB, and Hepatitis B and C. Services provide state-of-the-art treatment practices that appropriately address gender, age, racial, ethnic, sexual orientation and disabilities. Geographic and economic environments are also considered in treatment. Recipients reflect a diverse range of service providers, including grassroots and indigenous community based organizations and entities of State and local government. The grantee programs are classified by target groups consistent with current surveillance data reflecting those most impacted by HIV/AIDS: women, women and their children, adolescents, injecting drug users, men who inject drugs and men who have sex with men.

Program Performance Analysis

Measure 1: Increase the number of clients served.

CSAT's primary mission is to bring effective alcohol and drug treatment to every community. The number of people served reflects the extent to which CSAT funding has supported the provision of service. Collection of GPRA core Client Outcome Tool. Action Plan: Previous targets were set on unreliable data as noted in the previous submission. CSAT has implemented a data reporting system, thus we now have final data and targets have been reset accordingly.

Measure 2: Increase the percentage of adults receiving services who (e) had no past month substance use.

The FY02 target was exceeded. The percentage of adults receiving services who had not used substances in the past month at 6 months post admission, reflects the extent to which CSAT funding has supported the provision of effective service. Measured by the collection of GPRA Core Client Outcome Follow Up Tool data. There is a relationship between performance and budgetary requests. Appropriation requests are based on the performance targets that are set.

Measure 3: To reduce risky behaviors associated with contracting HIV and other infectious diseases: (a) Sexual risk behaviors (b) Other risk factors.

Target indicators for 2001 have been met. Data is not yet available for FY02; supplemental data availability lags behind core data in the new GPRA reporting system. This is measured by the collection of Core GPRA Client Outcome Tool data in addition to supplemental risk data. There is a relationship between performance and budgetary requests.

2.29 Program Title: TCE: Community-Based Substance Abuse and HIV/AIDS Outreach Program

Performance Goals Strategic Goal:	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of client contacts. (O, E)	FY 05: 224,400 FY 04: 220,000 FY 03: 210,000 FY 02: 200,000	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 202,408	**HHS SP -1**
2. Increase the percentage of adults receiving services who: (e) had no past month substance use. (O)	FY 05: 54.7% FY 04: 52.7% FY 03: 45%** FY 02: 40%	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 48.7%	
Total Funding:	**2005: $0** **2004: $0** **2003: $0** **2002: $0** **2001: $9,556,200** **2000: $2,600,000**		

** The apparent discontinuity in the FY03 and later targets is the result of a shift in FY04 to using revised targets that are consistent with our long-term PART goals.

Program Description and Context

The HIV/AIDS Outreach Program was designed to develop community-based outreach projects to target African American, Latino/Hispanic and other racial/ethnic minority communities experiencing high rates of substance abuse and HIV/AIDS. Outreach is conducted among chronic, hardcore drug users and their sex and/or needle-sharing partner(s), other racial/ethnic women with children, injecting drug users, men who have sex with men, minorities, and adolescents.

The funds for this program are included in the TCE funding line, however, for reporting performance, this program is reported separately from the TCE line at the request of the Congress.

This program targeted change in drug using behavior and encouraged treatment by successfully employing outreach techniques to reach these high risk drug using populations. SAMHSA awarded grants to community-based organizations with outreach experience in reaching chronic, out-of-treatment and hard to reach substance abusers. These SAMHSA funded grant programs were culturally competent, gender sensitive, age appropriate and customer driven (family and consumer) in their approaches.

Programs are involved in the following activities to reach those goals: 1) offering HIV/AIDS risk reduction interventions; 2) providing medical diagnostic testing and screening for HIV, STDs, TB, and pregnancy; 3) providing community-based outreach services to encourage entry and facilitating access to substance abuse treatment; and 4) providing linkages and primary medical care, mental health and social services, as well as other means to effect behavior changes to decrease the risk of acquiring or transmitting HIV, STDs, TB and related diseases. Among the agencies funded were public and domestic private nonprofit and for-profit entities

such as units of State and local government, community-based organizations, and State or private universities, colleges and hospitals. Eligible organizations had to be located in a city with an AIDS annual case rate of 20/100,000 population or a State with an AIDS case rate of 10/100,000 population or beginning in FY 2001 in metropolitan areas with a minority AIDS rate of greater than 25/100,000. SAMHSA funded those geographic areas deemed to be at highest risk for HIV transmission. In order to be funded, applicants had to provide evidence of providing outreach services for a minimum of two years.

Program Performance Analysis

Measure 1: Increase the number of client contacts

Relevance: CSAT's primary mission is to bring effective alcohol and drug treatment to every community. The number of people served reflects the extent to which CSAT funding has supported the provision of service.

How is this measured: Collection of Core GPRA Client Outcome Tool.

Relation of Measure to Budget Request: It is expected that an increase in budget allocation will result in more clients being served.

Performance on Measure 1: The FY02 target has been exceeded, with 202,408 contacts being made.

Measure 2: Increase the percentage of adults receiving services who: (e) who had no past month substance use.

Relevance: CSAT's primary mission is to bring effective alcohol and drug treatment to every community. The number of people served reflects the extent to which CSAT funding has supported the provision of service.

How is this measured: Collection of Core GPRA Client Outcome Tool.

Relation of Measure to Budget Request: It is expected that an increase in budget allocation will result in more clients being served.

Performance on Measure 2: The FY02 target was exceeded.

2.30 Program Title: Screening and Brief Intervention, Referral and Treatment

Performance Goals *Strategic Goal:*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of clients served. (O, E)	FY 05: TBR 11/03 FY 04: TBR 11/03 FY 03: (Establish baseline)	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: Program Start Up	**HHS SP -1**
2. Increase the percentage of clients receiving services who: (e) had no past month substance use (O)	FY 05: TBR 11/03 FY 04: TBR 11/03 FY 03: (Establish baseline)	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: Program Start Up	
Total Funding:	**2005: $50,000,000** **2004: $50,000,000** **2003: $23,000,000**		

Program Description and Context

Screening, Brief Intervention, Referral and Treatment (SBIRT) is a new program component, being initiated at the end of FY03. There is an emerging body of research and clinical experience that supports use of the SBIRT approach as providing effective early intervention for those persons who are nondependent users of illicit drugs. These cooperative agreements are to expand and enhance State substance abuse treatment service systems by developing the State's continuum of care to include screening, brief intervention, referral, and treatment (SBIRT) in general medical and other community settings (e.g., community health centers, school-base health clinics and student assistance programs, occupational health clinics, hospitals, emergency departments); supporting clinically appropriate treatment services for nondependent substance users (i.e., persons with a Substance Abuse Disorder diagnosis) as well as for dependent substance users (i.e., persons with a Substance Dependence Disorder diagnosis); improving linkages among community agencies performing SBIRT and specialist substance abuse treatment agencies; and identifying systems and policy changes to increase access to treatment in generalist and specialist settings. It is estimated that approximately 7 States/Indian Tribes will receive awards in FY 2003.

Program Performance Analysis

Measure 1: Increase the number of clients served.

CSAT's primary mission is to bring effective alcohol and drug treatment to every community. The number of people served reflects the extent to which CSAT funding has supported the provision of service. This is measured through the collection of Core GPRA Client Outcome Tool data.

Measure 2: Increase the percentage of clients receiving services who (e) had no past month substance use.

The percentage of clients receiving services who had not used substances in the past month at 6 months post admission, reflects the extent to which CSAT funding has supported the provision of effective service. This is measured through the collection of Core GPRA Client Outcome Follow Up Tool.

2.31 Program Title: Substance Abuse Prevention and Treatment Block Grant

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-* *Reference*
1. Number of Clients served: (O, E) Note: Baseline, targets, and proxy performance data currently provided by TEDS data set (see text), which reports admissions data.	FY 05: 1,950,000 FY 04: 1,925,345 FY 03: 1,884,654 FY 02: 1,751,537 FY 01: 1,635,422 FY 00: 1,525,688	FY 05: TBR 9/07 FY 04: TBR 9/06 FY 03: TBR 9/05 FY 02: TBR 9/04 FY 01: TBR 9/03 FY 00: 1,599,701 FY 99: 1,587,510 FY 98: 1,564,156 FY 97: 1,537,143	**HHS SP - 1**
2. Increase the number of States and territories voluntarily reporting performance measures in their SAPT Block Grant application. (O)	FY 05: 25 FY 04: 25 FY 03: 25 FY 02: 25 FY 01: 25 FY 00: 19 Baseline established	FY 05: TBR 9/05 FY 04: TBR 9/04 FY 03: TBR 9/03 FY 02: 26 States/Territories reported some or all information. FY 01: 25 States reported some or all information. FY 00: 24 States reported some or all information FY 99: 0 States	
3. Increase the percentage of States that express satisfaction with Technical Assistance (TA) provided. (O)	FY 05: Maintain at 97% FY 04: Maintain at 97% FY 03: Maintain at 97% FY 02: Maintain at 97% FY 01: 97% FY 00: 90% FY 99: 85% Baseline established	FY 05: TBR 9/05 FY 04: TBR 9/04 FY 03: TBR 9/03 FY 02: 92% FY 01: 97% FY 00: 97% FY 99: 96%	
4. Increase the percentage of TA events that result in systems, program or practice change. (O)	FY 05: Maintain at 95% FY 04: Maintain at 95% FY 03: Maintain at 95% FY 02: Maintain at 95% FY 01: 85%	FY 05: TBR 9/05 FY 04: TBR 9/03 FY 03: TBR 9/03 FY 02: 97% FY 01: 96%	

	FY 00: 70% FY 99: 66% Baseline established	FY 00: 84% FY 99: 66%	
5. Increase the percentage of Block Grant applications that include needs assessment data. (O)	FY 05: 97% FY 04: 95% FY 03: 93% FY 02: 90% FY 01: 85% FY 00: 80% FY 99: 72% Baseline established	FY 05: TBR 9/05 FY 04: TBR 9/04 FY 03: TBR 9/03 FY 02: 100% FY 01: 88% FY 00: 80% FY 99: 72%	
6. Increase the percentage of States that indicate satisfaction with CSAT customer service, throughout the entire Block Grant process. (O)	FY 05: 98% FY 04: 98% FY 03: 96% FY 02: 95% FY 01: 93% FY 00: 91%	FY 05: TBR 9/05 FY 04: TBR 9/04 FY 03: TBR 9/03 FY 02: 95% FY 01: 91% FY 00: 91%	
7. Increase the percentage of States reporting satisfaction with CSAT=s responsiveness to State suggestions on services. (O)	FY 05: Maintain at 96% FY 04: Maintain at 96% FY 03: 96% FY 02: 95% FY 01: 94% FY 00: 93%	FY 05: TBR 9/05 FY 04: TBR 9/04 FY 03: TBR 9/03 FY 02: 91% FY 01: 90% FY 00: 93%	
Total Funding:	**2005: $1,806,300,000** **2004: $ 1,785,000,000** **2003: $ 1,753,932,000** **2002: $ 1,725,000,000** **2001: $ 1,665,000,000** **2000: $ 1,600,000,000** **1999: $ 1,585,000,000** **1998: $ 1,360,107,000**	(These are budget totals before deducting 20% Prevention Set-Aside.)	

Program Description and Context

The SAPT Block Grant, the cornerstone of States= substance abuse programs, is an integral part of the President=s Drug Treatment Initiative. It accounts for approximately 40% of public funds expended for prevention and treatment.

The SAPT Block Grant is allocated to the States by a formula prescribed in the Public Health Service Act. The grant provides States the flexibility to plan, carry out, and evaluate substance abuse services. More than 10,500 community-based organizations receive SAPT Block Grant funding from the States.

Development of performance measures continues to be an area of highest priority for the SAPTBG. The Performance Partnership Block Grant Performance Measures are in the process

of being developed and cleared by SAMHSA. It is expected that some States may be able to report on initial performance data in time for the 2005 block grant application.

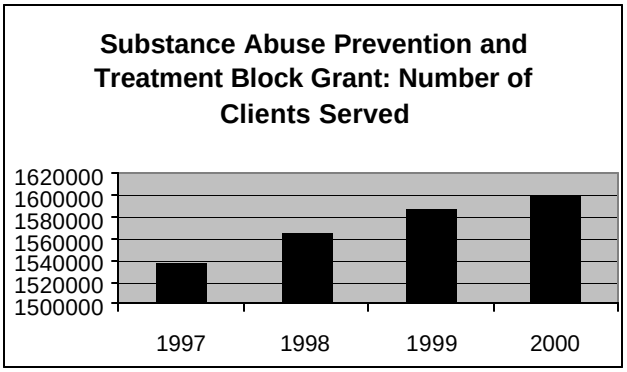
Program Performance Analysis

Strategies for Block Grant Performance Measures: CSAT, in anticipation of the provisions of the Children=s Health Act, has approached performance measures development using a two-pronged strategy. First, CSAT is providing incentives to States/Territories to pilot the collection of performance-based measures through grant mechanisms. Second, CSAT is also promoting consensus-building efforts among key stakeholders to refine the list of measures used in the Treatment Outcomes and Performance Prospective Pilot Studies (TOPPS II) project. CSAT=s effort to pilot States= capacity to collect data on a small subset of the core measures began with the FY00 Substance Abuse Prevention and Treatment (SAPT) Block Grant application and resulted in FY03 with 26 States/Territory voluntarily reporting on these performance measures (see Measure 2).

Three barriers to effective performance measurement remain. First, the cost of conducting client outcome studies is significant even on a small representative sample. Second, there is also a need to develop data infrastructure and management within their State systems to carry out this initiative. Third, State capacity to utilize performance measurement is varied. A CSAT study through the National Association of State Alcohol and Drug Abuse Directors (NASADAD) examined what States are currently doing and found that 1) Only 24 of the 56 States reviewed reported that they were able to submit studies for analysis; and 2) periodicity of studies conducted, methodologies, and measure definitions used, vary significantly across the States.

Measure 1: Number of clients served.

The FY00 target was met. Proxy data on this measure for FY01 will be available in September 2003. CSAT's primary mission is to bring effective alcohol and drug treatment to every community. Knowing the number of clients contacted and served reflects the extent to which CSAT funding has supported the provision of service in support of the President's drug treatment initiative. This is measured through the Treatment Episode Data Set of the SAMHSA National Household Survey on Drug Use and Health.



Reporting of the exact number of clients served in Block Grant funded facilities remains under development. Tracking the unduplicated number of clients served by each State, which is the ideal way of reporting these data, requires that systems employ a unique client identifier. States are working toward providing unduplicated counts. Twenty-three States and Territories were able to report unduplicated counts in FY02. Some States, however, are unable to report this information due to laws prohibiting the use of unique client identifiers and data system limitations. Therefore, the targets projected for the SAPT Block Grant are based on the number of client admissions reported by TEDS data source. The number of client admissions reported is counted annually in the fiscal year being reported. The availability of TEDS data, like other major public health data sets such as births and deaths, are also reported on 2 year lag periods. The sole data source used to determine the actual performance achieved on this target measurement will continue to report with a two-year lag period for the annual GPRA submission. Given that federal funding for services are in-part provided to increase availability and to increase responsiveness to state identified need, tracking numbers served is a critical component of any cost-benefit analysis.

Measure 2: Increase the number of States and territories voluntarily reporting performance measures in their SAPT Block Grant application.

The TOPPS II process is currently developing an approach that will be viable for all of the States as an infrastructure development activity. Complete adoption by all States will take some time following the development work that will continue to be monitored on an annual basis. The adoption by all States under the Performance Partnerships Grant would focus on State systems accountability by requiring States to measure current performance, set targets and adjust State system activities and priorities based on State=s performance relative to these targets. Data will be collected by community-based providers funded with block grant funds using standard instruments which will be administered to clients by trained interviewers. Data will be forwarded by the providers to the SSA=s for analysis and subsequent reporting to CSAT, using Section IV-A of the SAPT Block Grant Application on nine treatment outcome measures as a reporting vehicle.

Performance on Measure 2: The FY02 target was met. Twenty-five States and Virgin Islands reported on some or all of the measures, met the target of 25, and exceeded it by one State (4% above the target). This is the third year States and Territories could report voluntarily on performance measures in their SAPT Block Grant application. A significant factor that may have affected States= interest in submitting these voluntary data is the evolving nature of the data elements. The FY03 Block Grant Application OMB approval will expire on July 31, 2004 to include collection of this critical information on nine outcome measures. States may be waiting for final guidance from SAMHSA to finalize the Performance Partnership Grant plan before committing additional resources to collecting these data. States have been made aware of CSAT=s current conceptualization of performance measurement under a system referred to as a performance partnership that offers States more flexibility in the expenditure of funds while basing accountability on performance and develops a partnership between the Federal Government and State governments in the provision of substance abuse prevention and treatment

services. The Performance Partnership Grant would focus on State systems accountability by requiring States to collect data in core client indicator areas and optional State-selected indices, measure current performance, set targets and adjust State system activities and priorities based on State=s performance relative to these targets.

Measure 3: Increase % of States that express satisfaction with Technical Assistance provided.

Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA=s technical assistance provided over the past 12 months. This is a specific satisfaction measure of technical assistance that will continue to be used in future years. CSAT conducts an annual customer satisfaction survey with the States/Territories on the block grant activities. The survey supports service improvements by allowing for a modification of the program process to better respond to customer needs. In FY02, 49 of the 60 jurisdictions, including the District of Columbia, and Puerto Rico (excluding the Pacific Basin, Red Lake and Virgin Islands) were surveyed to determine the level of satisfaction with SAPT=s block grant process, technical assistance, core technical review, needs assessment, and other services provided over the past 12-month period. The data source is an OMB-approved Customer Service Survey that is mailed annually to State Substance Abuse Directors to complete and is forwarded to CSAT contractor for data analysis and a final report is prepared. Reliability and validity were assessed as part of survey design, development, and pilot implementation, and were determined to be high.

Performance on Measure 3: The FY02 target was not met at 97%. In FY02, 49 of 60 jurisdictions including the District of Columbia, Puerto Rico (excluding Pacific Basin and Virgin Islands) were surveyed to determine the level of satisfaction with CSAT=s Technical Assistance (TA) in the last 12 months. Combining the two highest categories (satisfied and very satisfied), the overall satisfaction was found to be 92%. States reported that CSAT technical assistance improves their credibility within their state. Combining the two highest categories (to a great extent and to some extent), the overall satisfaction was found to be 92%. Ninety percent of the States were overall satisfied or very satisfied with technical assistance received by CSAT.

Measure 4: Increase % of Technical Assistance events that result in systems, program or practice change.

Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA=s technical assistance to the States has resulted in systems, program or practice change provided over the past 12 months. This is a specific satisfaction measure of technical assistance that will continue to be used in future years. CSAT conducts an annual customer satisfaction survey with the States/Territories on the block grant activities. The survey supports service improvements by altering the program process to better respond to customer needs.

The data source is an OMB-approved Customer Service Survey that is mailed annually to State Substance Abuse Directors to complete and is forwarded to CSAT contractor for data analysis and a final report is prepared. Reliability and validity were assessed as part of survey design, development, and pilot implementation, and were determined to be high.

SAMHSA is committed to integrating its budget narrative and GPRA plan within the Health and Human Services format. Current plans for integrating budget and performance planning and reporting includes key budget and performance planning activities within the same unit in time for the FY04 budget activities

Performance on Measure 4: The FY02 target for this measure was met. 100% of the States reported that CSAT's technical assistance has led to some improvement in treatment delivery or management systems. This is a 3% increase from FY01 survey results (97%). Some examples of States that reported on implementation of systems changes resulted from CSAT technical assistance are as follows:

> "The statewide conference was a highly visible tool for engaging stakeholders, sharing new information, raising awareness/educating policymakers, providers, consumers and state staff. The collaborative contracting project promoted collaboration and enabled the state to make steady progress in changing an entrenched and complex contract system."
>
> "Technical assistance has assisted us in development of our future data system."
>
> "The state has clear guidance for overseeing and integrating services for clients with co-occurring alcohol/drug and mental health providers."
>
> "Technical assistance offered in methadone office-based treatment practice prepared us for the upcoming CSAT accreditation process."

The target for FY03 has been set at 95% and is expected to be maintained at 95% in FY04. These targets are deemed to be reasonable based on the fact that the number of additional States that will be surveyed for this performance measure is small. The various technical assistance events offered to the States/territories vary widely in focus, complexity and level of effort. The technical assistance projects are designed for States to make requests on a voluntary basis and do not necessarily result in the same number of technical assistance requests received from year to year.

Measure 5: Increase percentage of Block Grant applications that include needs assessment data.

Section 1929 {U.S.C. 300x29} of the Public Health Service Act as amended by Public Law 106-310 Submission to Secretary of Statewide Assessment of Needs and 45 C.F.R. 96.3 requires States to submit an assessment of the need in the State for authorized activities by the States and locality. States readiness for statewide needs assessment planning process is currently operational but will need further refinement and infrastructure capacity building that will prepare states to identify state treatment service priorities, and activities for data collection purposes on the uniform PPG core performance measures and optional State-specific measures coupled with evaluation and feedback information on progress made in meeting the state goals and targets established.

The data source is the annual uniform SAPT Block Grant Electronic Application System that generate aggravated reports on states= submission of treatment Needs Assessment Summary Matrix (TNASM) (form 8) and State Use of Needs Assessment Information (SUNAI) (form 10). States are required to report needs assessment data on the TNASM form. States must explain how the State arrived at the numbers entered on the form, the biases of the data, and how the State intends to improve the reliability and validity of its data. The SUNAI (form 10) reports on how States use state generated or CSAT State Treatment Needs Assessment data funded project for selected specified purposes. CSAT is forwarded generated reports from its BGAS contractor and analyze the data for reporting on this measure. Reliability and validity of states and territories reporting on Form 10 was piloted and assessed in FY99 SAPT block grant application that determined a baseline of 72%.

SAMHSA is committed to integrating its budget narrative and GPRA plan within the Health and Human Services format. It is Congress' intent that CSAT State Needs Assessment funding to States and/or State generated needs assessment data is used to target SAPTBG funding to communities severely impacted by substance use and trade.

Performance on Measure 5: The FY02 target was met. All of the States and Territories (100%) (met and exceeded target by 15%) reported in their FY03 SAPTBG application on some or all of the needs assessment summary data matrix form using the last calendar year for which the State have the data. States and Territories also reported on multiple uses of state needs assessment data on the SUNAI (form 10). Many States view state needs assessment data as a planning tool that assist in management decisions about resource and/or method allocation to better serve communities in greatest need for substance abuse services. A majority of the States (86%) use needs assessment data for services planning and public information. While 69% of the States use needs assessment data for legislative initiatives, a number of states continue to use needs assessment data to allocate new funding (58%) and/or allocate historical funding (48%) to treatment providers.

Measure 6: Increase percentage of States that indicate satisfaction with CSAT customer service, throughout the entire Block Grant process.

Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA=s customer service to the States throughout the entire Block process provided over the past 12 months. This is a specific satisfaction measure of CSAT customer service in processing SAPTBG applications and will continue to be used in future years. CSAT conduct an annual customer satisfaction survey with the States/Territories on the block grant activities. The survey supports service improvements by altering the program process to better respond to customer needs.

The data source is an OMB-approved Customer Service Survey that is mailed annually to State Substance Abuse Directors to complete and is forwarded to CSAT by its contractor for data analysis and final report preparation. Reliability and validity were assessed as part of survey

design, development, and pilot implementation in FY00, and were determined to be high at a baseline established at 91%.

Performance on Measure 6: FY02 performance target was met. The actual performance on this measure was 95%. However, the actual performance level achieved remains relatively high. In FY02, CSAT and CSAP developed new procedures for staff to follow that streamlined the review process of SAPTBG applications to improve efficiency of internal operations. There was an increase of 11% (82%) from FY01 survey results of 71% of States reported that the SAPTBG approval process is effective or very effective to the current level of 82%. In addition, in FY03 a CSAT and CSAP Block Grant Re-Engineering Workgroup was established to develop new guidelines for working with the States under the new performance partnership grant application plan. CSAT continues to implement a State Project officer (SPO) feedback system for each staff person that receives a separate evaluation based on the State data provided, and this information is discussed individually with the SPO. To complete this TQM process, the overall Customer Satisfaction Survey evaluation findings are discussed at the division meeting for input to address staff strengths and areas of improvement. This process is expected to result in further improvement in satisfaction with CSAT customer service.

Measure 7: Increase percentage of States reporting satisfaction with CSAT=s responsiveness to State suggestions on services.

Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA=s overall customer service to the States. This is a specific satisfaction measure on reporting States= satisfaction with CSAT=s responsiveness to State suggestions on services. CSAT conduct an annual customer satisfaction survey with the States/Territories on the block grant activities. The survey supports service improvements by altering the program process to better respond to customer needs. The data source is an OMB-approved Customer Service Survey that is mailed annually to State Substance Abuse Directors to complete and is forwarded to CSAT by its contractor for data analysis and final report preparation. Reliability and validity were assessed as part of survey design, development, and pilot implementation in FY00, and were determined to be high at a baseline established at 93%.

Performance on Measure 7: The FY02 performance target 95% was not met. The customer satisfaction data reported 91% of states are satisfied or very satisfied with the responsiveness of CSAT to State suggestions by combining the two highest categories (satisfied and very satisfied). The actual performance level achieved remains relatively high.

Other Program Types

2.32 Program Title: Other: Opioid Agonist Medical Maintenance and Opioid Treatment Program (OTP) Accreditation — Performance Measures

Performance Goals *Strategic Goal: Capacity*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of patients affected by opioid agonist medical maintenance exemptions. (O, E)	FY 05: 1,300 FY 04: 1,275 FY 03: 1,000 FY 02: 750 FY 01: 500 FY 00: Establish baseline	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 565 FY 01: 533 FY 00: Baseline 250	**HHS SP-1**
2. Reduce the average turnaround time for processing of single-patient exceptions. (O)	FY 05: Maintain at 60% FY 04: maintain 60% FY 03: 60% reduction (to 32 hrs.) FY 02: 50% reduction (to 40 hrs.) FY 01: 40% reduction (to 48 hrs.) FY 00: Establish baseline	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 40 hours FY 01: 42 hours FY 00: Baseline 80 hours	
4. Increase the number of OTPs that achieve accreditation pursuant to Title 42 of the Code of Federal Regulations (CFR), Part 8.* (O)	FY 05: Maintain at 1100 FY 04: 1100 FY 03: 900 FY 02: 136	FY 05: TBR 8/05 FY 04: TBR 8/04 FY 03: TBR 8/03 FY 02: 139	
Funding:	**FY 2005: $2,190,000** **FY 2004: $3,790,000** **FY 2003: $2,950,000** **FY 2002: $2,295,976**		

*Measures 3 and 5 dropped per discussion with OMB.

Program Description and Context

Administrative responsibility and oversight for opioid drugs in the treatment of opiate addiction shifted from the Food and Drug Administration (FDA) to SAMHSA on May 18, 2001 under Title 42 of the Code of Federal Regulations (CFR) Part 8. This shift established a new regulatory system based on an accreditation model. These responsibilities are mandated by the Comprehensive Drug Abuse Prevention and Control Act of 1970 and the Narcotic Addict Treatment Act of 1974. In developing this program CSAT worked closely with FDA to modernize Federal opioid agonist treatment regulations by preserving provisions which help to safeguard public health and safety while allowing for more clinical flexibility. The new treatment regulations have two major objectives: to increase patient satisfaction and patient retention in treatment and to expand opioid agonist treatment capacity.

Stabilized and socially responsible patients undergoing opioid agonist medical maintenance treatment are permitted, under the supervision of qualified practitioners, to reduce the frequency of clinic visits and to increase quantities of take-home medication. These provisions, although

scientifically proven for select populations of patients, are not currently permitted by the regulations unless a program-wide exemption has been granted to an opioid treatment program under 42 CFR § 8.11(h).

Accreditation is the peer review process by which SAMHSA-approved accreditation bodies make site visits and review the policies, procedures, practices and patient services of an organization providing opioid treatment. The purpose of these accreditation site visits is to ensure that OTPs meet specific, nationally-accepted standards regarding organizational functioning and patient care. SAMHSA and CSAT's grants to support the accreditation of Opioid Treatment Programs will help to defray the costs of accreditation for the estimated 1100 OTPs nationwide which must become accredited under 42 CFR Part 8 by May 19, 2003. In extraordinary circumstances, OTPs may be granted an extension to become accredited by May 19, 2004.

Program Performance Analysis

Measure 1: Increase the number of patients affected by opioid agonist medical maintenance exemptions.

CSAT provides substance abuse treatment services funding and monitors opioid agonist medical maintenance in order fulfill its responsibilities under Title 42 of the Code of Federal Regulations Part 8. Opioid agonist medical maintenance exemptions are critical in meeting the goals of the treatment regulations which are to increase patient satisfaction and retention in treatment and to expand opioid agonist treatment capacity.

As a part of their regulatory responsibility, CSAT staff members maintain contact with opioid treatment programs which report periodically on the number of patients enrolled in opioid agonist medical maintenance. CSAT staff report these totals periodically as GPRA performance measures. It is expected that as budget allocations increase, proportionately more clients may be served more cost-effectively within well-equipped and accredited treatment programs.

Performance on Measure 1: The number of patients affected increased to 565 in FY02, but did not meet the target of 750. This occurred largely because fewer programs than expected applied for opioid medical maintenance exemptions for a variety of reasons, including more stringent regulation of methadone medical maintenance in some States.

Measure 2: Reduce the average turnaround time for processing of single-patient exceptions.

SAMHSA/CSAT regulates opioid treatment programs and provides substance abuse treatment services funding; responsiveness to services providers is an important outcome to monitor for good quality customer service.

CSAT maintains a database which records the processing time required for single-patient exceptions. A CSAT contractor produces periodic electronic reports which calculate average processing time which is reported as a GPRA performance measure.

In terms of the relation of the Measure to budget request, the single-patient exception request is a required regulatory function under CFR 42 Part 8. As the efficiency of processing these requests improves, it is expected that a smaller portion of budget allocations will be required for this function. Although a portion of the budget will always be required for this function, funds which are conserved may be used for other important and emergent regulatory priorities.

Performance on Measure 2: The FY02 target was met. The turnaround time for processing single-patient exceptions was significantly reduced.

Measure 4: Increase the number of OTPs which achieve accreditation pursuant to Title 42 of the Code of Federal Regulations (CFR), Part 8.

The FY02 target was exceeded. CSAT provides substance abuse treatment services funding and regulation, and ensuring quality care through accreditation is a vital function for this agency.

The five SAMHSA-approved accreditation bodies are required by regulation to submit periodic reports on the OTPs which have been accredited. SAMHSA/CSAT maintains a database of accredited OTPs through a contractor. CSAT staff monitor the reports and generate validated totals from the database to employ as a GPRA performance measure.

It is expected that that as budget allocations increase, CSAT will be able to support the accreditation of more OTPs; this will result in a larger number of patients receiving quality treatment, resulting in improved patient outcomes.

2.33 Program Title: Access to Recovery (ATR)

Specific performance measures are being developed and will be presented in the GPRA submission to OMB.

Program Description and Context

In FY04, the budget includes new funding of $200 million for a drug and alcohol treatment voucher program (Access to Recovery) targeted to States. This increase is part of the President's commitment to provide an additional $1.6 billion for treatment services over five years. This program will complement the FY03 State Targeted Capacity Expansion Program. Both are key components of the Presidential initiative to increase substance abuse treatment capacity, consumer choice, and access to a comprehensive continuum of treatment options (including faith-based programmatic options). Further, this program also will serve as a model, allowing States to initiate the type of treatment voucher systems permissible with SAMHSA grant funding under the proposed Charitable Choice regulations. Funding will be allocated as

competitive grants. States awarded these grants will have flexibility in customizing their voucher programs to fit each State's unique needs, provided that the State's policies, programs and practice adhere to key principles of this initiative.

States participating in the program may use a range of models for implementing treatment vouchers, including full implementation by a State or sub-State agency or implementation of all or part of the program through partnership with a private entity. Within a State, the program may be targeted to areas of greatest need or areas where there is a high degree of readiness to implement the program. As part of this program, States must establish a process for screening, assessment and referral to treatment that is appropriate for the individual client – from brief interventions to more intensive treatment. Also program referrals must ensure that clients have a genuinely independent choice of appropriate treatment providers. States must ensure full and open competition among public and private, proprietary and nonproprietary providers (including faith and community-based organizations) for designation as participating providers in the voucher program. States also must develop plans to enable providers that have not been able to compete effectively for federal funds to do so in this program without compromising program outcomes. States must establish a process to monitor the outcomes and costs of the voucher program and to make adjustments based on the extent to which improved client outcomes are/are not achieved in a cost-effective manner. The key to accountability in this program will be the system of reimbursement. Payment to providers will be linked to demonstration of treatment effectiveness measured by such indicators as client substance use following discharge.

Substance Abuse National Data Collection

The Office of Applied Studies (OAS) serves as a focal point for the data collection, analysis, and dissemination activities of information vital to national treatment, prevention and research efforts. OAS collects and analyzes data on the incidence and prevalence of substance abuse, the distribution and characteristics of substance abuse treatment facilities and services, and the costs of substance abuse treatment programs. Surveys conducted by OAS are the only source of national data on the extent of substance abuse in the general population and the characteristics of the treatment system. They also provide critical information for evaluating the success of Federal and State substance abuse programs.

Programs included in this section all report results on an annual basis. They are focused on achieving Goal 4: Strengthen data collection to improve quality and enhance accountability.

Programs include: National Survey on Drug Use and Health (formerly the National Household Survey on Drug Abuse); Drug Abuse Warning Network; and Drug Abuse Services Information System

2.34 Program Title: Substance Abuse National Data Collection

Performance Goals	*Targets*	*Actual Performance*	*Refer-ence*
1: Availability and timeliness of data for the: (a) National Survey on Drug Use and Health (b) Drug Abuse Warning Network (c) Drug and Alcohol Services Information System (O,E)	FY 05: Maintain at: (a) 8 months; (b) less than 9 months; (c) less than 16 months after close of data collection FY 04:Maintain at: (a) 8 months; (b) less than 9 months; (c) less than 16 months after close of data collection FY 03:Maintain at: (a) 8 months; (b) less than 9 months; (c) less than 16 months after close of data collection FY 02:Maintain at: (a) 8 months; (b) less than 9 months; (c) less than 16 months after close of data collection FY 01:Maintain at: (a) 8 months; (b) less than 9 months; (c) less than 16 months after close of data collection	FY05: TBR September 2005 FY 04: TBR September 2004 FY 03: TBR September 2003 FY 02: Data available within: (a) 8 months; (b) 8 months; (c) 13 months; targets reached. FY 01: Data available : (a) within 8 months; (b) 7 months; (c) 12 months; targets reached. FY 98 Baseline: National data were available: (a) 8 months after close of data collection; (b) 12 months; (c) 13 months after close of data collection	**HHS SP-1**
Total Funding:	**2005:** **(a) $47,500,000** **(b) $14,500,000** **(c) $8,600,000** **2004 :** **(a) $45,800,000** **(b) $12,800,000** **(c) $11,700,000** **2003:** **(a) $41,200,000**		

	(b) $18,500,000 **(c) $8,700,000** **2002:** **(a) $43,785,000** **(b) $9,947,000** **(c) $11,400,000**		

Program Description and Context

The *National Survey on Drug Use and Health* (NSDUH) is conducted under the legislative authorization of Section 505 of the Public Health Service Act (42 U.S.C. 290aa-4) which authorizes data collection for monitoring the prevalence of illicit substances and the abuse of licit substances in the United States population. The goal of the NSDUH is to provide critical estimates of the prevalence of substance abuse at the national level and in the 50 States and the District of Columbia. This survey collects annual data on substance abuse based on a national probability sample of the civilian population age 12 and older. The survey provides data on the extent of substance abuse and perceptions of risk in the population, and the sociodemographic characteristics, criminal, and other behavioral activities of individuals with a substance abuse problem.

In 1999, the sample size of the survey increased from 25,000 to 70,000 so as to generate State level estimates of substance abuse prevalence. Effective with the 1999 NSDUH each State will have information for improving treatment and prevention efforts. Other benefits from the increase in the NSDUH sample include improved precision of the estimates for youth between 12 and 17 years of age, the ability to study substance abuse in those over age 55 years, and separate, national estimates for additional minority groups (the survey previously provided estimates for some minority groups), such as Chinese or Japanese Americans, that were not captured with the smaller sample. The product of this initiative is important, accurate, and timely data to be used as performance measures by the Office of National Drug Control Policy and other Federal and State agencies engaged in efforts to reduce substance abuse.

The *Drug Abuse Warning Network* (DAWN) is authorized by Section 505(c)(1)(A) and (B) of the Public Health Service Act (42 USC 290aa-4), which require the annual collection of data on the number of individuals admitted to emergency rooms of hospitals as a result of the abuse of alcohol or other drugs and the number of deaths occurring as a result of substance abuse, as indicated in reports by coroners. The goal of this program is to provide timely estimates of drug-related emergency department visits at the national level, and for 21 large metropolitan areas. This program obtains information on the number and type of drug-related admissions to emergency departments and drug-related deaths identified by medical examiners. DAWN data are relied on by other Federal agencies.

DAWN data are especially important to the Federal effort to reduce drug abuse, which uses the data to detect new or emerging problems and to establish priorities for area surveillance. For example, the Drug Enforcement Agency uses DAWN data for surveillance and resource allocation. In addition, DAWN data are also used by the Food and Drug Administration (FDA)

to identify problems with licit drugs that can not be detected with the limited samples employed in clinical trials.

The *Drug and Alcohol Services Information System* (DASIS) is implemented under authorization of Section 505(c)(1)(C) through (F) of the public Health Service Act (42 USC 290aa-4) which require annual collection of information on the services available for substance abuse treatment in the United States, and on the characteristics of patients admitted to treatment. This program provides both national and State level information on the substance abuse treatment system. DASIS contains information on the characteristics and services of all known treatment programs in the country, and information on patients admitted to treatment programs receiving public funds. This data is important to both consumers and public agencies that serve them.

For example, public information about substance abuse treatment facilities is made available to the public through a new Treatment Facility Locator System now available on the SAMHSA web site (http://findtreatment.samhsa.gov). The Treatment Facility Locator System permits individuals seeking substance abuse treatment to find a facility in their area providing the type of treatment and services they seek. Helpful street maps indicate the exact location of the facility and travel routes; accompanying text describes the services available and other information, such as type of payment accepted.

DASIS also provides data necessary for the calculation of the treatment gap, a performance measure used by the Office of National Drug Control Policy to assess progress in the effort to reduce substance abuse. Information from DASIS is also used to compile the National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs, which is used extensively for treatment referrals. In addition, the data provide information for a sampling frame that is used by investigators conducting research on the quality of substance abuse treatment.

Performance Analysis

All three surveys have consistently met their target for availability of data despite the complexity of collecting, editing and processing large data sets.

Faith-Based Initiative

2.35 Program Title: Faith-Based Initiative

Faith-Based and Community Initiative

Performance Goals *Goal 1: Assure services availability*	*Targets*	*Actual Performance*	*Refer-ence*
1. Determine the number of faith based and community representatives who are SAMHSA grant reviewers	FY 05: TBR 12/03 FY 04: TBR 12/03 FY 03: Estab baseline	FY 05: TBR 12/05 FY 03: TBR 12/04 FY 03: TBR 12/03	
2. Determine the number of grant applications received from faith-based and community groups	FY 05: TBR 12/03 FY 04: TBR 12/03 FY 03: Estab. baseline	FY 05: TBR 12/06 FY 04: TBR 12/05 FY 03: TBR 12/03	
3. Determine the number of faith-based and community organizations participating in technical assistance, including technical assistance on grant writing and on SAMHSA's Charitable Choice provisions.	FY 05: TBR 12/03 FY 04: TBR 12/03 FY 03: Estab. baseline	FY 05: TBR 12/06 FY 04: TBR 12/05 FY 03: TBR 12/03	
	No direct funding		

Program Description and Context

The goal of this program is to ensure that faith-based and community groups have access to SAMHSA funding and programs as one of the President's priorities. SAMHSA needs to establish baseline information on the number of faith based and community representatives who are SAMHSA grant reviewers and other performance information to ensure the full participation of faith-based and community organizations in SAMHSA programs. As this initiative has unfolded, formerly measures #1 and #5 have been dropped to reflect changing policies and resources.

Performance Analysis

Measure 1: Data is being compiled to report baselines and set targets in 12/03.

Measure 2: SAMHSA plans to use a form developed by the Department of Education to establish baseline information on applicants who identify themselves as "faith-based/religious organizations." Once complete information for Measure #2 is collected, a new measure will be substituted to track the success of these applicants with SAMHSA's grant process.

Measure 3: Data has been collected and analyses will be started in the Spring of 2003 for reporting in December 2003.

Program Management

This section includes performance goals in areas that support programs in achieving the Agency's mission.

Programs include:
2.36 Information Technology
2.37 Human Capital Initiative (Restructuring and Delayering /SAMHSA's Workforce Planning)

2.36 Program Title: Information Technology (IT)

Performance Goals Goal 1: Assure services availability	Targets	Actual Performance	Refer-Ence
1. Increase web site visits to the SAMHSA site (O)	FY 05: TBR 9/03 FY 04: 95,000,000 FY 03: 90,000,000 FY 02: 60,000,000 FY 01: Estab. baseline	FY 05: TBR 9/05 FY04: TBR 9/04 FY03: TBR 9/03 FY 02: 62,000,000 FY 01: 51,534,724	
2. Ensure that all SAMHSA contracting personnel have signed a confidentiality agreement (O)	FY 05: Measure to be dropped FY 04: 100% Completion FY 03: 100% Completion FY 02: 100% Completion FY 01: Baseline	FY 05: FY 04: TBR 9/04 FY 03: TBR 9/03 FY 02: 100% FY 01: Zero agreements.	
3. Deletion of all user accounts upon termination (O,E)	FY 05: Measure to be dropped FY 04: 100% Completion FY 03: 100% Completion FY 02: 100% Completion FY 01: Baseline	FY 05: TBR 1/05 FY 04: TBR 1/04 FY 03: TBR 9/03 FY 02: 100% FY 01: Approx. 80 accounts not deleted.	
Total Funding:	**2005: $39,100,000** **2004: $34,000,000** **2003: $36,100,000** **2002: $7,780,000** **2001: $6,930,000**	New budget info. consists of req. contained in Exhibit 53 for IT	

Program Description and Context

SAMHSA's Information Technology (IT) mission is to support SAMHSA's program accomplishment by ensuring that efficient and effective technology resources are available to all SAMHSA components. In addition, IT ensures that resources are properly used to support the technology needs of the programs and SAMHSA's external customers. Providing good customer service to all customers is a high priority.

Improvements in IT systems support have improved SAMHSA performance. For example, IT is emphasizing improvements to information security as one of the President's Management agenda priorities in order to protect the reliability and integrity of SAMHSA's informational technology from intrusion. Currently, a strategy is in place to improve the security, integrity and capability of SAMHSA's information technology infrastructure. For example, three goals of IT's security and service strategy are:

1. Develop and implement formal security incident response policies and procedures;

2. Continue to upgrade surveillance software to collect data and thwart intrusions into the IT system, and

3. Addition of module to SAMHSA Grant Information Management System (SGIMS) to automate functions.

To support these strategies to improve service and security performance, IT has developed specific performance measures. It is anticipated that data furnished from the measures will be used for IT management decision making. Performance measures will help to ensure responsive and high quality IT services.

Performance Analysis

Measure 1: SAMHSA uses WebTrends Professional Suite to record the number of visits to the SAMHSA Internet Web site per month. Visits are counted by the number of files being served to consumers by the server. During FY 2002, the average number of visits on the SAMHSA Web site reached a total of over 62 million exceeding the target. As more information is posted to the site, we expect to reach 90,000,000 visits by the end of FY 2003. There is automated tracking of data with WebTends software, for high data validity and reliability.

Measure 2: Contractors provide all system development, network support and IT security activities for SAMHSA. These contractors are responsible for ensuring data and server integrity. The confidentiality agreement, now required, details individual responsibility to protect sensitive information, the required actions or procedures to follow, and the appropriate security point of contact to notify in case of an incident.

To minimize communication loss, data destruction, data disclosure, data integrity loss, sabotage, theft of assets, resource mismanagement, misuse of IT equipment, a confidentiality agreement

will be required by written policy. This process in working with contractors needs to be tracked for several years to ensure that it is fully implemented as a systematic procedure.

IT program policies, procedures and administrative records will supply the data for this performance measure. Data validity and reliability are high.

Measure 3: Network support routinely deletes access for all personnel immediately upon termination of their employment with SAMHSA. However, IT security, in coordination with HR and/or administrative services, ensures that written procedures are followed to delete all access for personnel immediately upon termination of their employment. The target has been achieved, but a performance trend is needed before the measure can be dropped.

2.37 Program Title: Human Capital Initiative

Performance Goals	*Targets*	*Actual Performance*	*Reference*
1. Increase the supervisor to staff ratio	FY 05: TBR 10/03 FY 04: TBR 10/03 FY 03: 1:8 FY 02: 1:7 FY 01: Establish baseline	FY 05: TBR 12/05 FY 04: TBR 12/04 FY 03: TBR 12/03 FY 02: 1:8 FY 01: 1:7	
2. Increase the staff to secretary ratio	FY 05: TBR 10/03 FY 04: TBR 10/03 FY 03: 12:1 FY 02: 11:1 FY 01: Establish baseline	FY 05: TBR 12/06 FY 04: TBR 12/05 FY 03: TBR 12/03 FY 02: 11:1 FY 01: 10:1	
3. Improve critical work processes and work process productivity measures for the following four areas: (1) development, review and management of discretionary grants; (2) publications clearance; (3) block and formula grants; and (4) systems for responding to external requests.	FY 05: TBR 10/03 FY 04: TBR 10/03 FY 03: Develop and initiate performance measure studies for the other two work areas; set baselines. FY 02: Develop and initiate performance measure studies for two of the work areas; set baselines.	FY 05: TBR 12/05 FY 04: TBR 12/04 FY 03: TBR - 12/03 FY 02: Studies initiated for both the discretionary grants process and the block and formula grants process to establish baseline and develop measures.	
Total Funding:	**Note: No direct funding appropriated.**		

Program Description and Context

SAMHSA's response to the President's Human Capital initiative is based on the results of a comprehensive Strategic Workforce Planning process that began in January 2000 and the

development of Restructuring Action Plans that were initiated in FY 01, refined in the first quarter of FY 2002, and implemented in phases in the second half of FY 2002. The Strategic Workforce Plan and the Restructuring Plan included the following goals:

1) To clarify the organizational purpose, ensure a strong leadership, and management capacity, and a well-structured organizational structure to support our mission.

2) To create effective work processes and methods for accomplishing SAMHSA's mission and optimizing the workforce, including consolidating administrative services where this would support overall goals.

3) To invest in the workforce by strategically recruiting, selecting and retaining talented employees through effective management and retention tools, and by developing competencies needed to achieve SAMHSA's mission.

4) To redeploy positions to "front-line" service positions to enhance the available resources for SAMHSA's citizen-focused and programmatic activities.

5) To ensure that SAMHSA functions as a single entity, with policy, program direction, and budget functions residing at the level of the Administrator.

In FY 02, policy analysis, budget formulation, budget execution and public affairs were centralized within the Office of Program Services (OPS) and the Office of the Administrator (OA). A number of small offices were eliminated and the functions integrated into larger organizational entities, and the OPS was restructured, reducing the number of Divisions and Branches, thus achieving a reduction in the number of supervisory positions and more efficient utilization of secretarial and support positions. Additionally, studies are underway to improve work processes employed in the administration of discretionary and block and formula grant programs.

Performance Analysis

Measure 1: The target was met.

For measure two, the target was met. Fewer resources are devoted to secretarial/support positions as the agency has realized and will continue to realize the economies/efficiencies that are possible through greater use of automated processed, e-government, and outsourcing. As a result, after meeting OMB directed reductions, these resources can be deployed to activities that are more citizen focused.

For measure three, two work areas have been selected for study. Efforts to develop performance measures have been initiated.

2.38 Program Title: Financial Management

Performance Goals	*Targets*	*Actual Performance*	*Refer-ence*
1. Results of most recent CFO Audit of SAMHSA Financial Statements. (O)	FY 05: Clean Opinion FY 04: Clean Opinion FY 03: Clean Opinion FY 02: Clean Opinion	FY 05: TBR 2/06 FY 04: TBR 2/05 FY 03: Clean Opinion FY 02: Clean Opinion	
Total Funding:	**FY 04: $200,000** **FY 03: $200,000** **FY 02: $200,000**		

Program Description and Context

SAMHSA has established its commitment to the President's Management Agenda by including management measures in the annual performance plan.

Performance Analysis

Measure 1: For 2003 and 2004, the Agency is committed to continuing to achieve a clean financial opinion.

Part V.

APPENDIX TO THE PERFORMANCE PLAN

A.1 Linkage from SAMHSA GPRA Plan to SAMHSA and HHS Strategic Plans

A new SAMHSA strategic plan is under development, and the HHS Strategic Plan has been revised. The current SAMHSA GPRA plan indicates which SAMHSA strategic goal each program supports. The following table indicates the HHS goals and objectives SAMHSA programs support.

FY 2005 GPRA LINKAGE TABLE

(Dollars in thousands)

HHS STRATEGIC OBJECTIVE	**FY 2003 Actual**	**FY 2004 Estimate**	**FY 2005 Estimate**[3]
GOAL 1: Reduce the major threats to the health and well-being of Americans			
Objective 1.4 Reduce substance abuse			
Substance Abuse Block Grant	$1,753,932	$1,785,000	$1,806,300
CSAT PRNS	$317,278	$556,816	$561,316
CSAP PRNS	$197,111	$148,186	$156,186
Objective 1.5 Reduce tobacco use, especially among youth			
Synar Amendment Implementation	$632,500	$650,000	$650,000
GOAL 2:Enhance the ability of the Nation's public health care system to effectively respond to bioterrorism and other health challenges			
Objective 2.1 Build the capacity of the health system to respond to public health threats in a more timely and effective manner			
Mental Health Block Grant	$437,140	$433,000	$433,000
Protection and Advocacy Program	$33,779	$32,500	$32,500
Mental Health PRNS	$244,443	$211,757	$238,257
GOAL 3: Increase the percentage of the Nation's children and adults who have access to regular health care and expand consumer choices			
Objective 3.5 Expand access to health care services for populations with special needs			
CMHS PRNS[2]	$10,560	$10,583	$10,607
CSAP PRNS[2]	$39,839	$38,100	$38,100
CSAT PRNS[2]	$61,691	$62,279	$61,195
Total:	3,616,183	3,817,259	3,877,559

[1] Note: the Substance Abuse Block Grant and CSAT/CSAP PRNS addresses both 1.4 and 1.5, as well as other objectives. Multiple objectives are met by SAMHSA funding lines, but a best fit to one objective has been implemented in the table.
[2] Note: Funding for HIV/AIDS broken out of PRNS aggregate.
[3] 2005 Budget Numbers subject to change.

A.2 Changes and Improvements in SAMHSA's GPRA Plan Over Previous Year

SAMHSA has substantially rewritten the GPRA plan and report for the 2002-2004 planning and reporting cycle. In addition to eliminating a considerable amount of text, specific improvements include:

- **$** 14% reduction in the number of measures from 2004 to 2005, emphasizing outcome and other key measures
- **$** Integration of budget and performance information in one document;
- **$** identification of efficiency and outcome measures for all 2005 programs;
- **$** revision of data verification and validation section;
- **$** following through on the performance measurement commitments made in the FY 2002 plan, obtaining needed data;
- **$** ongoing development of new long-term measures in conjunction with the OMB PART review, and
- **$** identification of measures that contribute to Healthy People 2010 goals.

A.2.B Summary Table of Changes to FY 2004/2005 Goals /Targets Over Previous FY

For the 2005 submission, additional measures were dropped to comply with HHS and OMB guidance to reduce, but also to add long-term and efficiency measures.

Center for Mental Health Services	
2.1 Statewide Family Network/ Statewide Consumer Network	Reporting combined. Measures 2 and 3 to be dropped for both programs in FY03.
2.2 Circles of Care	Measures 2 and 3 to be dropped in FY03
2.3 National Mental Health Information Center	Measure 1 to be dropped in FY 03. The three parts of measure 2 consolidated into a single measure in FY 03.
2.5. Housing Initiative II	Program dropped from report in FY 2003
2.6 HIV/AIDS Minority Mental Health Services	Measure 2 to be dropped in FY 03; measure 3 to be dropped in FY 03 and replaced with new measure reflecting percentage of clients with treatment plans
2.7 Comprehensive Community Mental Health Services for Children and their Families	Measure 1 to modified for FY 03 to reflect to reflect total number of children receiving services rather than average number per grant; two parts of the three-part measure 3 to be dropped in FY 03; measures 5, 6 and 7 to be dropped in FY 03
2.8 Protection and Advocacy	Measure 3 to be dropped in FY 03
2.9 PATH	Measure 2 to be dropped in FY 03
2.10 Community Mental Health	Measures 1and 2 to be dropped in FY 03; new measures added in FY 03:

Services Block Grant	number of people served; readmission rate within 180 days of discharge from inpatient care; rate of State-operated inpatient mental health service utilization per 100,000 population; percent of consumers reporting improved outcomes
Safe Schools/Healthy Students Initiative	Never fully reported in plan; Department of Education has the lead for GPRA reporting.

Center for Substance Abuse Prevention	
2.22 Substance Abuse prevention and Treatment Block Grant:	Measure 1- Increase the # of states that incorporate needs assessment into the Block Grant. Rationale- Target met- 100% of all states and jurisdictions. It is anticipated that the measure will be dropped in 2004. Measures 4-6 are being dropped in FY03.
2.21 Synar Program	Measure 2- Maintain periodic technical assistance for implementation of guidelines. Rationale- consistently at 100% for the last four years.
2.20 HIV Prevention Initiative	Measure 2- Increase age of first sexual encounter for youth receiving services which integrate substance abuse prevention and HIV prevention. Rationale- Measure 1 is a CSAP mission measure so should be retained. Measure 3 reports on the # of services provided which is a question frequently asked Therefore Measure 2 seemed less important.
2.13 National Public Education Effort	Measure 1 (b)- Visits to press release area of PREVLINE. Rationale- SAMHSA assumed full responsibility for all press releases therefore this measure is no longer appropriate for CSAP performance.
2.14 Starting Early Starting Smart	Measure 1- SAMHSA and Partners execute Memoranda of Understanding- Rationale- the original target was achieved and further MOUs aren't likely given the program is ending.
2.17 Centers for the Application of Prevention Technologies	Measure 1- Increase clients' satisfaction with CAPT services provided. Rationale- Measure 2 reports on the number of services CAPTs provided which is a question frequently asked. Measure 3 is the outcome measure for the CAPTS which is critical to retain. Therefore, Measure 1 is lesser in importance.
2.16 Family Strengthening	Measure 1- The study Sites will fully document the decision making for selecting the scientifically based program for implementation in their local communities. Rationale- It was more important to retain measure 2 which is the outcome measure for this program.
2.18 Community Initiated Prevention Intervention Studies	Measure 3- Develop or enhance infrastructure to prevent methamphetamine, ecstasy, club drug or inhalant use. Rationale- the program opted to retain Measures 1 and 2 which are both outcome measures for the program.

Substance Abuse National Data Collection	
NSDUH (National Survey on Drug Use and Health)	Measure 2 - Deleted in order to meet HHS targets for reductions of measures. Remaining measures consolidated as indicators for Measure 1 in FY 2003 for 2004 and 2005.

Center for Substance Abuse Treatment	
2.23 TCE General Populations 2.25 TCE: Comprehensive Community Treatment Program (Measures dropped for both adults and children) 2.32 TCE: HIV 2.33 TCE: HIV Outreach Program	The following measures are being dropped in FY 2003 for the listed programs to respond to HHS capitation ceilings on the numbers of measures: Increase % of adults receiving services who: (a) were currently employed or engaged in productive activities; (b) had a permanent place to live in the community; (c) had no/reduced involvement with the criminal justice system. (d) experienced no/reduced alcohol or illegal drug related health, behavioral, social, consequences Note: For the 2005 submission to OMB, reporting on TCE program measures will be aggregated
2.26 TCE Practice Improvement Collaborative	2. Increase % of stakeholders who: (a) are satisfied with KA events or activities (b) have shared information from KA events or activities with a colleague; (c) have used information from KA events or activities to promote or effect change.
2.27 Community Action Grant	1. Number of KA events 2. Shareholders will report satisfaction with consensus building events
2.32 TCE: HIV	To reduce risky behaviors associated with contracting HIV and other infectious diseases: (c) social/cultural risk factors (d) substance abuse
2.33 TCE: HIV Outreach	3.Reduce the % of clients who report risky behaviors associated with HIV/AIDS and other infectious diseases
2.34 SAPT Block Grant	5. Measure slightly modified to clarify the data source. The STNAP was ended, however, the data source remains the block grant application
2.29 ATTC	1a. Number of Knowledge Application Events. 2. Increase % of stakeholders who: (a) are satisfied with KA events or activities (b) have shared information from KA events or activities with a colleague;
2.30 Knowledge Application Program	1. Increase the number of targeted, products produced: a. New Treatment Improvement Protocols b. Revised New Treatment Improvement Protocols c. Other primary and companion products (e.g.: New resource documents, Quick Guides, KAP Keys, Substance Abuse in Brief, other periodicals)

2.40 Faith-Based and Charitable Choice Program	In 2003, measures 1 and 5 were dropped to reflect policy changes In 2002, Measures 5.6 and 8 were dropped. Measure 7 has been renumbered #5. Beyond policy changes, the measures dropped due to resource considerations of what was needed to implement data collection and analysis.

A.3 Partnerships and Coordination

SAMHSA's programs contribute to the missions and goals of other HHS Op Divs and reciprocal benefits from other Op Divs performance contribute to SAMHSA's mission and achieve a unique synergy to serve the Nation. It is important to emphasize that SAMHSA shares responsibility for long-term performance outcomes such as reduction in the national rates of substance abuse with many different Federal, State, Community and non-profit partners. Working with a broad array of Federal and other partners and stakeholders is critical to the achievement of agency priorities.

SAMHSA has a key role in bringing together partners and stakeholders, helping to ensure that efforts are complementary, and in ensuring that SAMHSA's priorities are based firmly in the needs of the field. SAMHSA's established networks with its grantees and external partners contribute significantly to the effectiveness of the agency. Partners and stakeholders include participation from multiple sectors:

- State and local governments, which administer the public mental health and substance abuse service systems;
- Non-profit treatment providers, such as community mental health clinics, substance abuse clinics and other community organizations;
- Other grantees or interested parties, such as hospitals, universities, community agencies and research institutes;
- Foundations, such as the Robert Wood Johnson Foundation, the Casey Family Foundation, and the Kaiser Family Foundation; and
- Current or former consumers/clients and their families.
- Faith-based and Community Organizations

Examples of Specific Federal Partners Include:

- The Office of National Drug Control Policy (ONDCP) coordinates the many Federal agencies involved in the national drug control effort. Some federal agencies focus on reducing the available supply of illegal drugs. SAMHSA shares its focus on demand reduction, and particularly prevention and treatment, with other agencies such as the National Institutes of Health, the Department of Education, and the Department of Justice. In addition, ONDCP establishes policies, priorities, and objectives for the Nation's drug control program, and determines and manages the National Drug Control Strategy. The Strategy directs the Nation's anti-drug efforts and establishes a program, a budget, and guidelines for cooperation among Federal, State, and local entities. SAMHSA's measures development efforts and decisions regarding targets are made in close cooperation with ONDCP, often based on findings from the NSDUH.

- National Institutes of Health (NIH) - NIH institutes closely work with SAMHSA and are vital partners in the "Science to Services" initiative. Primary links are with the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the National Institute of Mental Health. SAMHSA works closely with the Institutes to identify interventions demonstrated to be effective through research and evaluation. The Science to Service process brings together researchers, service providers, consumers and families, and government officials at all levels to speed the introduction of evidence-based practices into the community. It also brings these groups together to identify areas where clinical service needs are great and where research presently does not give adequate direction, thereby providing focus for Institute research agendas and SAMHSA Science to Service transmission activities.

- Department of Education (DOE) - Provides leadership for disseminating evidence based strategies in elementary, secondary and post-secondary education for reducing youth and young adult substance abuse. This includes ensuring that professional counseling programs integrate science based material into the curriculum. DOE has formed a collaboration with SAMHSA and other partners called the " The Safe and Drug-Free Schools Program." This program is designed to prevent violence in and around schools, and strengthen programs that prevent the illegal use of alcohol, tobacco, and drugs. Programs involve parents, and are coordinated with related Federal, State and community efforts and resources.

- Department of Justice (DOJ) - DOJ includes the Drug Enforcement Agency, the FBI, and the Office of the U.S. Attorney. DOJ is involved in interdiction and prosecutions relating to the supply of illegal drugs. Reducing the supply of highly addictive drugs such as cocaine and heroin is critical to reducing the treatment gap. DOJ also has a number of initiatives that contribute directly to demand reduction and the reduction of the treatment gap. These include serving as a partner in the federal collaboration to a address school violence and administering the Drug Free Communities Program, providing grants to prevent drug abuse.

A.4 Data Verification and Validation

CMHS –-Methods for Verification and Validation

Program	Verification and Validation Information
2.2: Statewide Family Network Program and Statewide Consumer Network Grants	Reporting on the variables will be done at the end of each of the three fiscal years of the grant by the grantee as part of the continuation application.
2.3: Planning, Designing, and Assessing Service System Models for American Indian and Alaska Native Children and Their Families (Circles of Care)	Reporting on the variables will be done at the end of each of the three fiscal years of the grant by the grantee as part of the continuation application.
2.4: National Mental Health Information Network	NMHIC data are collected by an OMB-approved on-line Internet user survey and tabulated by a database as they are collected. The data are monitored and analyzed for patterns of user responses and other trends. Results of the analyses determine enhancements to the Web site. Reliability of data has been found to be high. Data on information requests, publications distributed, and website contacts come from monthly reports from the NMHIC contractor. These monthly summaries provide accurate reports on various aspects of the NMHIC project. Validity of data is high.
2.5: Community Action Grants for Service Systems Change	Data on achieving consensus come from a contracted evaluation conducted on the first round (1997) of Phase I awards. Evaluation was based upon written reports and verified by telephone interviews. Reliability of the data is high. Data on service implementation comes from final reports submitted by grantees, including process evaluations. These reports are reviewed to determine if practices were implemented. Reliability of the available data has been found to be high.
2.5: Housing Initiative II	Study sites are implementing an outcome evaluation and participating with the coordinating center in conducting a cross-site study. Data are collected at baseline, 6 months and 12 months. Eighteen month data will be collected on a subset of the clients. Data on residential stability are collected by means of a residential follow-back calendar that determines where the person has been living each month during the previous twelve months. Data on contact with the criminal justice system and victimization are collected by self-reports from respondents. The Coordinating Center combines the data from all respondents at all sites and reports an aggregate percentage. A number of quality control activities are used to assure that the data are reliable and valid.
2.6: HIV/AIDS Minority Mental Health Services	Data for this program will be obtained from grantee program records and management information systems.
2.7: Comprehensive Community Mental Health Services for Children and Their Families	The average number of new children served was calculated by dividing the total number of new children *enrolled* across grant communities beyond the mid-point of their six-year grant period during a given fiscal year, by the number of these grant communities funded during that year. For calculating this average, the decision was made to select only grant communities beyond the mid-point of their six-year grant period, as they best approximate the capacity

	expected from grant communities. In FY 2001, there were 23 grant communities funded who were beyond the mid-point of their six-year funding period. Another 22 communities were still on their first or second years of funding. The national evaluator uses monthly reports of new children enrolled in each grant community to develop these figures. The figures in these monthly reports are then aggregated across the 12 months of a given fiscal year. Beginning in FY 03, this measure will be changed to reflect total number of children served. The methodology for this measure is being developed. Data on the two referral indicators are obtained from family caregiver reports. However, the data for the case record review indicator are derived from document reviews collected during annual site visits. Analyses have indicated that the correlation between case record review data and family caregiver report data, specifically for referral source data, was 0.862 (p=.000), indicating the reliability of the measures. The scale used to assess inpatient-residential treatment was an adapted version of the Restrictiveness of Living Environments Scale and Placement Stability Scale (ROLES) developed by Hawkins and colleagues (1992). An analysis showed that the percentage of agreement between data from the ROLES and data from a management information system in one grantee community was 76%. Data on children's outcomes are collected from a multi-site outcome study. Delinquency is reported using a self-report survey. Validity analyses were conducted for school attendance and law enforcement contacts. School attendance was found to have a positive relationship with school performance. Children who attended school frequently also had some tendency to receive good grades. The correlation between the two was .313 (p = .000). In addition, contacts with law enforcement were found to be positively correlated with clinician-reported community role (e.g., children's involvement with the legal system and delinquent behaviors. The correlation between the two was .313 (p = .000). Data on family satisfaction with services were derived from the Family Satisfaction Questionnaire (FSQ), a measure widely used and recognized for its reliability and validity. Validity analyses indicated that there was a positive correlation of .263 (p = .000) between the FSQ, a care giver-reported instrument, and youth self-reported satisfaction. Data on clinical outcomes were derived from Reliable Change Index (RCI) scores (Jacobson & Truax, 1991), calculated from entry into services to six months for the Total Problem scores of the Child Behavior Checklist (CBCL, Achenbach, 1991). The Reliable Change Index (RCI) is a standardized method developed by Jacobson and his colleagues to measure change between two data points. The RCI has a clear-cut criterion for improvement that has been psychometrically tested and found to be sound (Jacobson & Truax, 1991). A number of authors have provided data that support the validity of the RCI in measuring response to intervention

	(Lunnen & Ogles, 1998; Speer, 1998; Speer & Greenbaum, 1995). The CBCL is a widely-used standardized instrument used with caregivers to assess children's emotional and behavioral symptomatology. The instrument has been normed on a national sample and proved to be both reliable and valid. The overall internal consistency of the instrument was 0.96 (Achenbach, 1991). In addition, the one-week test-retest reliability was 0.89 (Achenbach, 1991). Furthermore, the CBCL also had significant correlations with two other instruments that measure similar construct, indicating its construct validity. The correlation between CBCL scores and those on the Conners (1973) *Parent Questionnaire* ranged from .59 to .86, and the correlation with those on the Quay-Peterson (1983) *Revised Problem Checklist* ranged from .59 to .88. (Achenbach, 1991).
2.8: Protection and Advocacy for Individuals with Mental Illness	Data sources for all PAIMI measures are the annual Program Performance Reports and Advisory Council Reports submitted annually by each of the P&A systems as required by the PAIMI Act. The information provided in the annual reports is checked for reliability during on-site PAIMI program visits, annual reviews, and budget application reviews. The information provided in each State's annual Program Performance Reports and Advisory Council Reports is reliable.
2.9: Projects for Assistance in Transition from Homelessness (PATH)	The source of the information is data submitted annually to CMHS by States, which obtain the information from local human service agencies that provide services. To improve the quality of the data, CMHS has developed additional error checks to screen data and contacts States and local providers concerning accuracy when data is reported outside expected ranges. CMHS has also issued guidance to all States and localities on data collection and monitors compliance with data collection through increased site visits to local PATH-funded agencies. PATH adopted quality control measures have eliminated much double counting of clients and will continue to improve data quality.
2.10: Community Mental Health Services Block Grant	The data source for the FY 1999 and FY 2000 core measures is the State Implementation Report, and data are considered preliminary. This report is required by statute and it is submitted annually by States on December 1. The State Implementation Report requires States to describe the extent to which they implemented the goals and objectives they set in the Block Grant plan for the past year. Since FY 1999, these reports have also requested States to report performance on the core measures; however, reporting is voluntary. Furthermore, if States choose to respond, they (1) interpret the measure, (2) define it, (3) determine the method for data collection, and (4) collect the data. As a result, the data is inconsistent and reliability is questionable. For example, 23 States in FY 1999 and 22 States in FY 2000 reported data on one or more of the core measures. While this would suggest some consistency, seven States (30%) that reported in FY 1999 did not report in FY 2000. Rather, six new States began reporting. Until data issues impacting reliability and validity are resolved, the data must be considered preliminary and cannot be used as the basis of management decision-making. The block grant program is working towards improving the quality

	of the data, as described in the Performance Partnership Grants approach. As part of addressing national deficiencies in mental health data, in 1999, 16 States began piloting a portion of 32 performance measures through the 16-State Pilot Project which was designed to develop uniform data and unduplicated counts of people served by the State Mental Health Authority. The pilot work on all 32 indicators has been completed and the results are available in a final report. Three new outcome measures have been added as interim measures based on the 16-State report.: percent of hospital readmissions within 180 days of discharge; rate of State-operated inpatient mental health services utilization per 100,000 population, and percent of consumers reporting improved outcomes. Data on readmissions and utilization rate will be collected from administrative records. Data on improved outcomes will come from surveys developed to assess perceptions of mental health services. An additional measure, number of people served, has been added to assess the impact of the program.

CSAP - Methods for Verification and Validation

Program	Information
2.21: Synar Amendment Implementation Activities	Analyses of compliance rates are performed each year based on data reported in the SAPT block grant applications. The data source is the Synar report, part of the SAPT block grant application submitted annually by each State. States must certify that Block Grant data are accurate. The validity and reliability of the data are ensured through technical assistance, conducting random unannounced checks, and the confirmation of the data by scientific experts, site visits and other similar steps. CSAP is able to provide leadership and guidance to States on appropriate sample designs and other technical requirements, based on scientific literature and demonstrated best practices for effective implementation of Synar. Data sources for the baseline and measures are derived from State project officers' logs and from organizations that were awarded State technical assistance contracts. The analysis is based upon the actual requests/responses received, therefore providing a high degree of reliability and validity .
2.11 State Incentive Grants (SIGs)	States have agreed to use the same instruments and to collect the same types of data. Data will be collected through several mechanisms: State grantees, local (local community or provider project level) and school and community-based surveys. Data are being sent to a CSAP data retrieval system for entry and analysis. Quality of the data is expected to be high. Past month use is an widely acceptable measure of drug usage; it is particularly useful in capturing the activity of new users; and it has the benefit of being common to national and State youth surveys. States will be measuring the reduction in youth substance abuse via State level measures, community level measures, and specific program measures to determine the effectiveness of science-based prevention programs and the effectiveness of the new prevention system. The decrease in risk indicators will also be examined. These and other data will be aggregated by CSAP through a central data coordinating system and cross-site comparisons will be conducted. Both the NSDUH, a national survey with known and

	established reliability and validity, and individual State school surveys will be used. NSDUH data alone will be used until the results of school surveys become available. States are responsible for local evaluations of a representative sample of these programs. In addition to the States' own evaluations of local programs, over the three years of their grants each State will report data from local subgroups of SIG funds to CSAP on a semi-annual basis for the national cross-site evaluation. The cross-site evaluation team is in the process of completing site visits during which they will evaluate program fidelity, adaptation, and implementation issues. Working toward performance based budgeting, CSAP is establishing and refining the SIG data collection system to gather information which will directly link cost to program participation. The next reporting cycle will include a measure which links States' SIG expenditures to the number of participants in SIG programs/activities. A baseline will be established for FY 2002.
2.20: Substance Abuse Prevention and HIV Prevention Initiative Program	It is expected that youth receiving substance abuse prevention services will have an increased perception of risk for substance abuse. These attitudes are expected to result in lower substance use. This program will use the SAMHSA GPRA cross-cutting instrument, which uses measures from reliable and valid instruments. Perception of risk has been shown to have high concurrent validity with drug and alcohol use and other negative behaviors. It is also expected that youth receiving integrated substance abuse prevention and HIV prevention services who have not yet begun sexual activity will delay their first sexual encounter, thus reducing their risk of HIV. The SAP/HIV program has developed a survey instrument using questions from established instruments to measure this goal. Data is being collected from individual sites on number, types, and quality of services.
2.12 National Clearinghouse for Alcohol and Drug Information (NCADI)	NCADI has several tracking systems to measure the processing of phone calls, mail, e-mail, staff requests, and web hits, and walk-in visitors. Each measure is reported to CSAP monthly and includes analyses of trends over time. All phone, e-mail, mail, staff, and walk-in requests are processed via NCADI's computerized order database tracking system (e.g., covers from the time a request comes in through the time that an order is closed out). The order tracking system is an Access database which is customized to serve the unique needs of the NCADI contract. Handling of call center operations is tracked by commercial software as well as by FTS2000 call activity reports to assess metrics such as length of call, time on hold, number of hang-ups. Website performance measures are drawn from Web trends, a commercial software package used to track web activity and performance. NCADI staff draws a random quality control sample from completed orders each month and customers are called during the following month. A customer service satisfaction (OMB clearance received 10/99) report is generated every 6 months and submitted.
2.13 National Public Education Efforts	The NCADI contract has several tracking systems to capture these data and report them to CSAP monthly. The Radio Newsline audience figures are generated based on published data on the market

	reach of radio news outlets. Calls to the Radio Newsline are tracked by commercial telephony software as well as by FTS2001 call activity reports. The website performance measures for Newsline (e.g., visits to press release area on PREVLINE) are drawn from Webtrends, a commercial software package used to track web activity and performance.
2.14 Starting Early/Starting Smart: Early Childhood Collaboration Project	Data are collected on the core measures for the cross-site study in four areas (parental functioning; child functioning; parent-child dyad; and service integration) by using multiple, standardized instruments to ensure reliability.
2.16 Centers for the Application of Prevention Technologies (CAPTs)	A new CAPT data collection system was effective on October 1, 2001 (FY 2002). Accordingly, new data from the old system is not available for reporting purposes. Baseline data for the proposed revised measures has been reported using the new system. The new national CAPT data collection system reflects a number of critical decisions about the most accurate and effective way to assess the work of the CAPTs. For example, the Technical Assistance (TA) database now focuses on overall TA services provided, and includes selected client ratings (satisfaction with and utility of CAPT service provided). The Event database now allows an examination of participant ratings (satisfaction with event and likelihood of using the information received). In future reports, these client satisfaction data will be provided. The new Systemic Outcomes database captures information on substantive changes that are in some way related to the work of the CAPTs. This redesigned data system represents a significant commitment to tracking the impact of CAPT work. Each CAPT follows a quality control protocol prior to collecting and submitting data, and CSAP has established an external quality control system through a support contractor overseen by CSAP staff.
2.15: Family Strengthening Study	Individual site data are obtained from program reports; documentation guidelines are provided by the Program Coordinating Center (PCC). Data are compiled into a cross-site report. The PCC developed a cross-site instrument, incorporating appropriate scales as recommended by CSAP's core measures work group and SAMHSA's GPRA measures (monthly use, perception of risk, disapproval, intention to use, and age of first use). To empower local evaluation and improve reliability and validity of data entry, a variable list and electronic database were distributed to Cohort 2 grantees to ensure that all sites will be coding the questions and responses the same way. Cohort 3 has a much more rigorous program evaluation design that includes control/comparison groups and three data collection points, pre and post-program exit.
2.17: Community-Initiated Prevention Intervention Studies	Using a self-report mechanism, this program measures how many participants in the intervention group used illegal drugs in the last 30 days. The program also looks to determine the effectiveness of sound substance abuse prevention strategies in promoting an increase in disapproval of substance abuse when applied across diverse populations.

CSAT Verification and Validation of Data Section

Program	Information
2.32: Substance Abuse Prevention and Treatment Block Grant	The number of clients served is a critical measure for the Block Grant program, particularly in light of the national goal to narrow the substance abuse treatment gap. TEDS admissions data have been used as proxy data to set targets and track results. However, the TEDS data represent admissions to treatment, not the total number of individual clients served. A person who presents for treatment twice during the data collection cycle will be included twice in the TEDS data set. TEDS admissions data do not capture either the total national demand for substance abuse treatment or the prevalence of substance use in the general population; data only represents admissions to treatment at facilities within the scope of TEDS data collection. SAMHSA has been working intensively with the Office of National Drug Control Policy to improve estimation methodology for the number of clients served, while efforts with States focus on improving their ability to collect unduplicated client counts. While still developmental, data for the planned Performance Partnership Grant measures will be collected by community-based providers using standard instruments which will be administered to clients by trained interviewers. Data will be forwarded to the SSA's for analysis and subsequent reporting to CSAT, using the Annual Block Grant Application as a reporting vehicle. Adoption by the States of these measures, following further developmental work, is an appropriate current measure for this critical activity. Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA's technical assistance. CSAT conducts an annual customer satisfaction survey with the States/Territories on the block grant activities. The survey supports service improvements and helps the Block Grant program to be more responsive to customer needs. Reliability and validity were assessed as part of survey development, and implementation, and were determined to be high. An effective measure of the impact of technical assistance is positive changes that result and are maintained in those systems, programs or practices addressed during the course of the technical assistance activity. Selected measures have been included in a tracking system used with those receiving CSAT TA. The validity and quality of data were assessed in the survey design and development process and found to be high. One of the statutory requirements for the SAPTBG is that states base their planning for the use of Block Grant funds on needs assessments within the state. Data are collected via the annual Block Grant Application System. A 1998 GAO report identified some problems with the completeness and accuracy of the data reported by the States, and recommended that CSAT develop a plan for making improvements. Validity of the data under this system is reviewed as part of the approval of funding and specific feedback provided to individual States. In addition, reviews of the data are done as part of a cyclical block grant compliance review process required by statute.
2.21 though 2.25; 2.28 through 2.30:	Standard outcome measures are in place for CSAT Targeted

Targeted Capacity Expansion	Capacity Expansion programs. The number of clients currently being served is a standard measure which is often reported in evaluation studies that examine treatment effectiveness. This item is an important accountability monitoring factor from which program performance can be estimated. Data are derived from reports and data sets submitted to CSAT by grantees. Data are generally collected at admission by the treatment program in order to assess an individual's substance abuse problem using the SAMHSA Core Client Outcomes Tool. The validity of the data is monitored by several data coordinating centers assigned to each program and who verify, clean and provide to CSAT GPRA data. In addition, the HIV and Outreach program collects HIV risk data through local evaluation efforts. Critical domains include:1) Sexual Risk Behaviors, 2) Other Risk Factors (e.g, tattooing, piercing, and other risk behaviors), and 3) Social and Cultural Context. The cross-site risk assessment tool and its instruction manual were developed and pilot tested, and grantees were trained in the tool's uniform administration. Data are collected at baseline, 6- and 12-month intervals.
2.26: Addiction Technology Transfer Centers (ATTCs)	ATTCs conduct educational events in a variety of formats, including training for continuing education, symposia, forums, conferences, workshops, and institutes. Maintaining high numbers of trainees is a critical measure. Each regional ATTC enters their data and submits the data to the National Office using two standard templates. Regional data files are checked, cleaned and merged. The PRE and POST training evaluation forms have been tested for internal consistency and results found that both have moderate to high levels.

A.5 Block Grant Data Collection – See Part

CMHS Community Mental Health Services Block Grant

GOAL: Implement the performance partnership required by the Children's Health Act of 2000.

DATA ISSUE: In addition to demonstrating programmatic efficiency and effectiveness, the Block Grant must collect data proving that persons with mental illness are having positive outcomes and experiencing an improved quality of life. CMHS is dramatically shifting data requirements to support a performance and outcomes-based approach.

STATUS:

- The FY 2002 through 2004 MHBG application includes a series of data tables developed collaboratively by MHBG staff and National Association of State Mental Health Program Directors. States and Territories were asked to report the data voluntarily. Response has been inconsistent.

- A Uniform Data Reporting System based on those tables is now being implemented through "State Mental Health Data Infrastructure Grants" in which 47 States are participating. Reporting (required as a condition of the grant) should increase each year. Participating States should be able to report all of the requested data by FY 2004.

- Comments on a Federal Register Notice (FRN) have been collected and analyzed. New measures have been developed and are in the process of being approved by the senior SAMHSA management and the Administrator.

CSAP - 20% Prevention Set-aside, Substance Abuse Prevention and Treatment Block Grant

Over the past several years, CSAP has worked with the States to develop appropriate process and outcome measures and to strengthen States' data infrastructure in order for them to be able to collect, report, and analyze performance data for the Block Grant. Currently, the block grant application requires very little prevention data. CSAP and the States have worked collaboratively to develop a data strategy that will benefit all parties.

- CSAP developed a disk-based Minimum Data Set for States to collect and analyze process data (numbers and characteristics of participants and services) on prevention programs. More than half of the States have received training on the program. It is now being incorporated into CSAP's web-based Decision Support System.

- CSAP, in collaboration with NASADAD and the States, developed voluntary outcome measures for the SAPT Block Grant. Although States have been slow to report on outcomes, primarily due to insufficient data infrastructure, the effort has laid the groundwork for proposed measures that have been published for comment in the Federal Register.

- CSAP has awarded 30 prevention needs assessment contracts to collect and analyze sub-state data on substance abuse, risk and protective factors, and community prevention resources. States use these data in planning and resource allocation.

- Work continues on a Decision Support System, which can be used to collect and analyze both process and outcome data as designed by the expert group, and is expected to be an important tool in prevention performance measurement.

- SAMHSA is continuing its efforts to improve its State data collection. Related to Performance Partnership Grants (PPG), SAMHSA has been working with the States and published a Federal Register Notice (FRN) on the Block Grant measures. The Agency has

collected and analyzed comments and has used to develop a list of new measures that are in the process of being cleared by senior management and the Administrator.

CSAT Substance Abuse Prevention and Treatment Block Grant

- **$** In FY 2002, working with NASADAD and other stakeholders, CSAT convened a series of task group meetings to develop consensus on development of data elements and processes for new waiver performance measures for the States. The Children's Health Act of 2000 allows waivers for a number of pre-existing and new block grant expenditure and programmatic requirements. Other possible measures that will be examined in partnership with NASADAD include penetration measures, state generated reporting measures, and complementary data sources. Linking of secondary data sources and social indicator data are also promising areas that will be pursued.

- **$** SAMHSA is continuing its efforts to improve its State data collection. Related to Performance Partnership Grants (PPG), SAMHSA has been working with the States and published on December 24, 2002 a Federal Register Notice (FRN) on the Block Grant measures. The Agency is waiting for comments.

- **$** CSAT and NASADAD will initiate a series of task group meetings to develop a new Web-based Block Grant application to facilitate performance partnership reporting. NASADAD will supplement the meetings with the Web-based Delphi process to expand consensus base.
- **$** CSAT's priority is to implement a data reporting system that will allow States the flexibility to report on the voluntarily outcome measures in the block grant application until the redesign of the performance measurement system has been approved by the Secretary for State mandatory reporting.

A.6 Program Evaluation and GPRA Measurement

SAMHSA continuously conducts program evaluation and performance measurement to ensure effectiveness and efficiency of its program investments. In addition, SAMHSA also conducts management evaluations to improve efficiency and effectiveness. Evaluation studies enable focus on broader questions to develop needed information for management. Evaluation findings directly support agency policy development and program management. Collaboration on evaluation with ASPE and other Op Divs has been facilitated through SAMHSA's participation and support of the Research Coordination Council.

SAMHSA evaluates each of its service programs so as to provide information to program managers about the accountability of Federal funds. Currently, SAMHSA is cooperating with NIH in developing a Sciences to Services initiative to speed best practices into use. Evaluation of these Sciences to Services programs is needed to monitor effectiveness in different populations and conditions.

Evaluation findings demonstrate the extent to which grant programs have achieved their overall objectives, and provide information for program and policy development, as well as to refine

strategies and performance objectives for future years. This evaluation policy helps SAMHSA achieve its goal of continually informing policy and program development with knowledge culled from past performance. This results in programs building on the success of preceding programs, in effect bench marking, so that SAMHSA can enhance the quality and relevance of publicly-funded substance abuse and mental health services.

A.7 Performance Measurement Linkages with Budget, Cost Accounting, Information Technology Planning, Capital Planning and Program Evaluation

Budget

Performance measurement linkages exist between the GPRA report and the budget for every SAMHSA program reported. All GPRA programs contain a reference to the budget narrative where more detailed information can be found. Performance measures contributing to the President's Management Agenda are marked with a icon in the reference column. The budget narrative now contains many citations from the performance plan and SAMHSA plans. Both documents have been streamlined so that they can again be printed as one volume.

Human Resources

SAMHSA completed its workforce plan. A careful workforce analysis was prepared for OMB to provide support for the plan that has been implemented during 2002. A performance plan to support this initiatives has been developed and is included with this submission in the Program Management Section.

Cost Accounting

SAMHSA maintains careful fiscal controls over planning, expenditures and monitoring the use of resources and recognizes the benefits of cost accounting for management decision making. In the past year, six specific areas were audited to ensure proper accountability. SAMHSA has fully implemented the Chief Financial Officer Act of 1990 by establishing the position of CFO, submitting a five year financial management plan with annual status reports and preparing the required annual financial statements. In addition SAMHSA is on schedule to complete its annual audited financial statement in order to fully implement the Government Reform Act of 1994 (GMRA). OPS has set a GPRA performance goal for a clean audit. Financial statements, supporting books and records for SAMHSA are prepared by the Division of Financial Operations Program Support Center (PSC). A CORE accounting system utilizes general ledger accounts and provides on-line query capability for accounting. The PSC's accounting systems are in accordance with the generally accepted auditing standards contained in the Government Auditing Standards issued by the Comptroller General of the United States and Office of Management and Budget Bulletin 93-06, "Audit Requirement for Federal Statements."

Information Technology

Improvements and new initiatives have been developed in response to this Administration's priorities. These are more fully discussed in the Information Technology submission in the Program Management Section of Part I of this report. A performance plan has been developed to focus on increasing the use of the web site and improve security of informational technology.

Capital Planning

In implementing GPRA and the Clinger-Cohen Act of 1996, SAMHSA considers how to make decisions in a business like context to ensure an acceptable return on investment (ROI) and to direct linkage of the department's mission and strategic objectives. SAMHSA is now in the process of developing formalized models of capital planning for implementation in Information Technology and other possible areas of operation.

A.8 Future Programs: FY 2003 - FY 2004

Substance Abuse and Mental Health Services Administration
FY 2004 Requested Priority Funding Initiatives

Program	**New Awards** *FY 03*	**New Awards FY 04**
Center for Mental Health Services		
1) Jail Diversion	X	
2) Prevention/Early Intervention	X	
3) Evaluation Technical Assistance Center	X	
4) State Evidenced Based Practice	X	
5) Post-Traumatic Stress Disorder	X	X
6) Community Action Grants	X	
7) Youth Violence Prevention	X	X
8) Consumer Technical Assistance Center	X	
9) Children's Mental Health Services	X	X
10) National TA Center for Children's Mental Health		X
11) Statewide Family Networks		X
12) Statewide Consumer Networks		X
13) Seclusion and Restraint SIG		X
14) State Data Infrastructure		X

Center for Substance Abuse Prevention		
1) Methamphetamine Interventions	X	
2) Ecstasy Prevention	X	
3) State Incentive Planning Grant	X	X
4) State Incentive Grant Enhancement	X	X
5) HIV/AIDS Prev. Interventions CSAP	X	X
6) Workplace/Youth Transition		X
Center for Substance Abuse Treatment		
1) Homeless Treatment	X	X
2) Targeted Capacity Expansion (General)	X	X
3) AI/AN Rural Planning	X	
4) Recovery Community Services Program	X	X
5) Targeted Capacity Expansion/HIV	X	X
6) Adolescent Alcohol Treatment Models	X	
7) Violent Offender Re-Entry (DOJ Lead)	X	
8) Screening, Brief Intervention, Referral to Treatment	X	X
9) Pregnant and Postpartum Women	X	
10) Strengthening Access and Retention	X	
11) Co-Occurring Supplements to ATTCs		X
12) Access and Retention Centers		X
13) Fatherhood and Family Re-entry		X
14) Access to Recovery		X
Cross-Center		
1) Co-Occurring State Incentive Grant (CSAT Lead w/CMHS)	X	X
2) Collaborative Initiative to End Homelessness (CMHS Lead w/CSAT)	X	
3) State Capacity for Emergency Response (CMHS Lead w/CSAT and CSAP)	X	X
4) National Indian Resource Center (CSAP Lead w/CSAT)	X	
5) Conference Grants (CMHS Lead)	X	X
6) Children's SIG		X
7) Minority Fellowship Program		X
Office of Applied Studies		
1) Dissertation Research Grant	X	

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